THE DIVISION OF LABOUR IN CHILD HEALTH CARE: POLAND AND ENGLAND & WALES COMPARED

by

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List of Abbreviations

Polish

DiP	Doświadczenia i Przyszłość (Experience and Future (discussion group))
GOZ	Gminny Ośrodek Zdrowia (Community Health Centre)
GUS	Główny Urząd Statystyczny (Central Statistical Agency)
IHWiU	Instytut Handlu Wewnetrznego i Usług (Institute of Home Trade and Services)
IMiDz	Instytut Matki i Dziecka (Institute of Mother and Child)
IPiSS	Instytut Pracy i Spraw Socjalnych (Institute of Labour and Social Security)
KOR	Komitet Obrony Robotników (Workers' Defence Committee)
MOiW	Ministerstwo Oświaty i Wychowania (Ministry of Education)
MPPiSS	Ministerstwo Pracy, Płac i Spraw Socjalnych (Ministry of Labour, Wages and Social Security)
MZiOS	Ministerstwo Zdrowia i Ochrony Społecznej (Ministry of Health and Social Welfare)
OBOP	Ośrodek Badań Opinii Publicznej (Public Opinion Research Centre)
PZPR	Polska Zjednoczona Partia Robotnicza (Polish United Workers' Party)
RSOZ	Rocznik Statystyczny Ochrony Zdrowia (Health Care Statistical Yearbook)
SKP	Społeczny Komitet Przeciwalkoholowy (Anti-alcohol Committee)
TPD	Towarzystwo Przyjaciół Dzieci (Society of Children's Friends)
WOZ	Wiejski Ośrodek Zdrowia (Rural Health Centre)
ZOZ	Zespół Opieki Zdrowotny (Integrated health care complex)
ZUS	Zakład Ubezpieczenia Społecznego (Central Insurance Agency)

List of Abbreviations

English

CMO	Clinical Medical Officer
CPAG	Child Poverty Action Group
DES	Department of Education and Science
DHSS	Department of Health and Social Security
EOC	Equal Opportunities Commission
GHS	General Household Survey
GNP	Gross National Product
GP	General Practitioner
HV	Health Visitor
NCOPF	National Council of One-Parent Families
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
OPCS	Office of Population Censuses and Surveys
SBC	Supplementary Benefits Commission
WHO	World Health Organisation

INTRODUCTION

The health of children is a matter of primary concern both to the state and to the individual, and the maintenance and restoration of that health are activities which take place both in the public domain and in the home. The recognition of the importance and interdependence of paid and unpaid labour is central to the conceptual framework of this study. It is a framework which views the division of labour in public and private domains not separately, but in terms of each other. This represents a break with classical sociological theories. Until feminists challenged the functionalist conception of the family as "natural" and unproblematic, these theories had been content with two discontinuous accounts of the division of labour: "one that it all began with Adam Smith and the other that it began with Adam and Eve" (Stacey, 1981: 172).

That is one aspect of the approach. The other lies in the comparative nature of the study, dealing as it does with two countries: Poland and Britain (1). An endeavour of this kind is hedged in by difficulties both methodological and interpretive, yet the sociological method <u>is</u> essentially a comparative one. Inevitably, a comparison of countries with varying ideo-political and economic systems is fundamentally concerned with the effect of these differences on particular social processes. Although this is also true of the present enquiry, what it does <u>not</u> set out to do is to counterpoint a notion

of capitalism with one of socialism, then to weigh up the merits of one over the other. This would be to assume that such a socialism exists and thereby to run the risk of subjecting evidence to what Gouldner (1980) has referred to as the self-normalising effect of theory.

Rather, the conceptualisation of the division of labour described above allows, firstly, a comparison which is sensitive to issues of both class and gender and the relation between the two. In this way the enquiry encompasses the major structural divides of British society, and at the same time confronts two of the major claims of state-socialist society: that it seeks to reduce social inequalities in general and to eliminate sexual inequalities in particular. It also provides the opportunity to draw comparisons which go beyond an institutional analysis to the level of personal experience. In linking public policy to the intimate matter of health it allows us to follow Mills' enjoinder that we should "grasp history and biography and the relations between the two within society" (Mills, 1977:12). If vital in the study of a single society, how much more so is the sociological imagination for a comparison of two countries with conflicting social systems?

This brief exposition of the conceptual background to the present study explains why an analysis of publicly provided health care in Poland and in Britain has been left to a single penultimate chapter. The initial task of the study was to establish a comparable notion of health and to examine the way in which this varies according to socio-economic group in each country. This is the subject of Chapter I and serves as a point of reference for what follows. Crucial to a

comparison of health and health care is its location within a material context. Chapters II and III note overall differences in national disposable wealth and focus on the consequences of markedly different systems for the production and distribution of that wealth which are adopted in each country. These are viewed, in Chapter II in terms of the levels and patterns of female economic activity rates - including economic activity in private farming, and the inter-relationships between these and the division of labour within the family. Chapter III reviews the evidence concerning the extent of social inequality and poverty which has been generated by these wealth producing and distributing processes. Following a short analysis of the division of domestic labour in the two countries in Chapter IV, Chapter V presents a wide-ranging comparative account of social policies relevant to child health. Again, these policies may be classified as either (a) serving to accommodate the employment of women with what are understood to be their domestic responsibilities or (b) serving to mitigate or in some other way deal with the consequences of social inequality and poverty. The study culminates in Chapter VI with an examination of specific state intervention in the maintenance and restoration of child health, and conclusions emerging from the study as a whole are presented in Chapter VII.

Two further points remain to be made. The first has to do with the nature of the source materials on which the thesis is based. These have been varied, and include the published writings of sociologists, medical sociologists, doctors and demographers in both Poland

and Britain. Official statistics and legislative texts have been consulted where appropriate. In addition, the data would have been much depleted were it not for the availability of a variety of reports produced in Poland for intra-institutional consumption. These reports emanate from the Central Statistical Agency (GUS), the Central Planning Commission, the Research Institute attached to the Ministry of Labour, Wages and Social Security (IPiSS), the Institute of Mother and Child (IMiDz) and also include a large number commissioned by the Council for the Family (Rada d/s Rodziny), a group of specialists convened in 1978 by Edward Gierek, as part of his "familialisation" of social policy. Details of all of these are to be found in the bibliography.

Finally, it is of some importance that the study is oriented towards a British readership. If greater weight has then been given to the Polish case, it is because a level of understanding of British arrangements has in places been assumed, the judgement having been that a proper comparison does not necessarily require a consistently even-handed approach, but that on the contrary, a fuller exposition of the less familiar is sometimes what is called for. Hopefully this judgement will be vindicated.

Notes

(1) In view of the possible complications arising from the quite separate legal and agency arrangements which exist in Scotland, England and Wales rather than Britain as a whole, figure in the title of this thesis, and where these have been available, figures for England and Wales have been used throughout the study. Nevertheless, much of the general argument applies to Britain as a whole, and where there has been nothing to indicate such extrapolation to be unwarranted, the words Britain and British may figure in the text.

CHAPTER I

THE BIOLOGICAL BASE

Introduction

In this chapter, I start out by defining and comparing the child populations in Poland and England and Wales (hereafter Eng/Wales) which are referred to in this study of child health care. Although my concern is with children and young people up to the end of school age (i.e. 18 or 19 years) for whom special health policy provision is made, not everywhere is data available for this population as a whole or exclusively. Much household budget data in Poland refers to families with dependent children under 24; other data may distinguish families with children under 16. I go on to consider health indices in the shape of infant mortality rates, how these are presented and interpreted and the relation of the knowledge generated to recommended policy for further reduction in the infant mortality rate - a declared goal in both countries. I argue that while there is evidence on both sides of structural determination of health inequalities, these implications are avoided in different ways, although ultimately an individual, cultural and therefore victim-blaming approach is heavily relied on in each case. While medical solutions are commonly proposed, the form of such solutions differ in some respects and are closely allied to the way health data is assembled and presented. This refers particularly to the identification (or not) of target groups to which it is suggested special attention should be paid.

Population Growth

While the 2nd World War has had long-term demographic repercussions in both Eng/Wales (the recurring "baby booms" of the late forties and sixties) and in Poland, destruction of the biological base was clearly incomparably greater in the latter case, and this is reflected in the 10 million population loss between the years 1939-50 shown in Table 1.1. Six million of this 10 million loss was due to death (the remainder caused by emigration and a redrawing of national boundaries), and inevitably a large proportion of the dead were women (thus reducing the country's reproductive capacity) and children - of whom there was an estimated 2 million toll (Balcerek, 1975: 40). Associated with this loss is the overall post-war population growth in Poland, 42.1 per cent as opposed to 12.5 per cent in Eng/Wales, and a more erratic fluctuation in the percentage of the total population constituted by children, although this percentage has remained consistently higher in Poland in the period under review. A falling British birth rate in recent years has meant that by 1980 the 0-4 age group was numerically greater in Poland than in Eng/Wales despite a considerably smaller total population (WHO, 1980: 11). Live births also exceeded those in Eng/Wales in that year, representing respective birth rates of 19.5 and 13.3 (ibid: 11, 15).

TABLE 1.1: Population of Poland and Eng/Wales 1939-1980 (in thousands) with number and percentage of children aged 0-14 years.

		1939	1950	1960	1970	1980	% increase 1950-1980
Poland	Total pop.	35,090	25,035	29,795	32,662	35,578	42.1
	Number aged 0-14 years	11,413	7,374	9,985	8,662	8,639	17.2
	% aged 0-14 years	32.5	29.5	33.5	26.5	24.28	-
Eng/Wales *	Total pop.	41,460	43,757.888	46,104.548	48,749.575	49,246	12.5
	Number aged 0-14 years	-	9,691.5	10,584.5	11,575.8	10,291	-
	% aged 0-14 years	-	22.1	23	23.7	20.9	-

* Figures for 1939, 1951, 1961, 1971 and 1980.

Source: For Poland: (1939-1970), Mantorska, I. (1979), Table 1, p.5; (1980), WHO (1982), p. 11.
For Eng/Wales: (1939-1970), Computed from OPCS (1982), Tables 1 and 5; (1980) WHO (1982), p. 11.

Infant Mortality

In both Poland and Eng/Wales, as internationally, the infant mortality rate remains the main index of national health and the main force behind health policies for pregnant women and children. The Polish programme for 1975-1990 for improving the health of the child population states as its first task "the improvement of ante-natal and obstetric care for the pregnant woman and her infant and a lowering of the infant mortality rate ..." (1), while in Britain medical arguments from the beginning of this century up to and including the Short report repeat this theme. It is also true that deaths in the first year of life account for the overwhelming majority of deaths in childhood - 79 per cent and 73 per cent of all deaths to children in the first 14 years of life in Poland and Eng/Wales respectively in 1980 (2). For this reason, and because they are generally more reliable than morbidity data, I concentrate on infant mortality data, the way such data are presented and interpreted and the bearing this has, if any, on health policy recommendations.

The Polish infant mortality rate has since 1963 been calculated according to a method which underestimates the rate by 3-5 pro mille as compared with the method previously used in Poland and that currently used in Eng/Wales (3). According to this method, the definition of a live birth is one where an infant has shown at least one sign of life (such as heartbeat, breathing, pulsating umbilical cord) and weighs at least 1000 gm, or has weighed between 601-1000 gm but lived

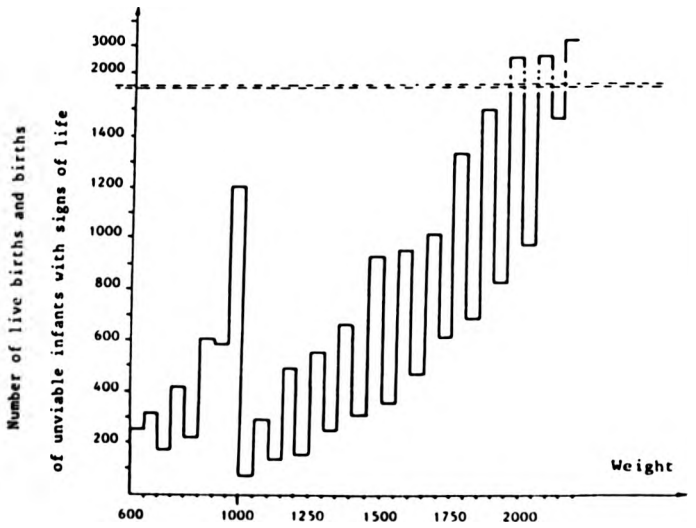
for more than 24 hours. Infants weighing between 601 and 1000 gm who have shown a sign of life but died within 24 hours of birth have since 1963 been assigned to a separate category of unviable infants showing signs of life, and as such are not registered among live births or infant deaths. Stillbirths are treated as they were prior to 1963, being registered where an infant which is dead on birth weighs over 1000 gm; where such an infant weighs between 601 and 1000 gm, the birth and death are not registered (4).

For its accuracy, this definition of a live birth clearly depends on the strict observance of criteria of both weight and time. Recent detailed evidence concerning the distribution of birth weights up to 2.2 kg. of all single live births and births of unviable infants showing signs of life which were registered in 1982, indicates that the process of classifying birth weight itself is a serious source of distortion and underestimation of infant mortality in Poland (Piasecki, 1984). This evidence is reproduced in Table 1.2, and represented graphically in Figure 1.1.

The figures show that there is a tendency to "round up" birth weights. They also show a striking tendency to classify birth weight just within the critical limit of 1000 gm. In 1982, 1200 infants were classified as having a birth weight of between 951 and 1000 gm, while only 78 were classified as weighing between 1001 and 1050 gm. In addition to this, a breakdown of the figures shows that the ratio of unviable infants showing signs of life to live births of infants weighing between 601 and 1000 gm is 2:1 implying that only one third

TABLE 1.2 & FIGURE 1.1: The distribution of birth weight among live births and unviable infants showing signs of life, where birth weight does not exceed 2.2 kg. (Poland, 1982).

Weight in gm	Number of infants	Weight in gm	Number of infants	Weight in gm	Number of infants
601-650	251	1151-1200	495	1701-1750	614
651-700	317	1201-1250	160	1751-1800	1334
701-750	177	1251-1300	556	1801-1850	692
751-800	418	1301-1350	254	1851-1900	1500
801-850	226	1351-1400	658	1901-1950	835
851-900	604	1401-1450	316	1951-2000	2539
901-950	586	1451-1500	935	2001-2050	970
951-1000	1200	1501-1550	361	2051-2100	2536
1001-1050	78	1551-1600	955	2101-2150	1469
1051-1100	293	1601-1650	471	2151-2200	3307
1101-1150	141	1651-1700	1016		



Source: Piasecki, E. (1984), Table 1, p. 5.

of infants with this birth weight survive longer than 24 hours (ibid). This indicates the possibility of a tendency to classify a death as occurring within rather than beyond 24 hours after birth. The effect of both tendencies is of course to increase the number of infants which may be classified as unviable but showing signs of life, by the same token decreasing the number of registered live births and infant deaths and in turn depressing the overall infant mortality rate.

Thus, both the method used for calculating the infant mortality rate and the way in which this method is implemented place significant restrictions on the extent on which Polish rates, and in particular the perinatal mortality rate, are directly comparable with those in Eng/Wales. These factors should be kept in mind in the analysis which follows, and are in part responsible for a concentration on variations in rates within countries rather than on contrasts in absolute terms between countries.

The dominating post-war trend has been the decline in the infant mortality rate in both countries and this is shown (with corrected Polish rates for 1965-82) in Table 1.3. The Polish infant mortality rate remains roughly double that in Eng/Wales, but the rate of decline over the 30 years has been steeper (taking 10-15 years less than the analogous reduction in Eng/Wales), although rates may now be seen to be flattening out in both countries. Infant mortality rates are perhaps most often presented along a temporal dimension to produce historical trends. They are also

commonly presented according to demographic categories such as the age and sex of infant and the age, parity or marital status of the mother; nosological categories; and general socio-economic categories which might be widely interpreted as including dimensions such as occupational class, geographical region, the urban/rural split, educational level, and combinations of these.

TABLE 1.3: Corrected and uncorrected infant mortality rates per 1,000 live births for Poland and Eng/Wales (1950-1982).

	1950	1955	1960	1965	1970	1975	1979	1982
Poland (uncorrected)	109.3	81.8	55.5	41.5	33.4	25.1	21.1	20.2
Poland (corrected)	109.3	81.8	55.5	44.6	37.5	29.4	25.2	24.4
Eng/Wales	29.6	24.9	21.8	19.0	18.2	15.7	12.0	10.8

Source: For Poland: compiled from Kondrat, Wł. (1978), p. 10, Kondrat, Wł. (1980), p. 90, IMiDz (1981), p. 7; Piasecki, E. (1984), Table 2, p. 5.

For Eng/Wales: HMSO (1981), p. 8; Population Trends, Winter 1984, Table 9, p. 42.

(a) Demographic categories

Polish and British infant mortality rates follow similar demographic patterns, being higher when mothers are aged under 20 or over 35, and where they are unmarried. Such categories are not independent of socio-economic factors. Rates are also higher among male infants, and deaths are generally more frequent the earlier the stage of life. Thus infant deaths are concentrated

within the neonatal period and in particular within the perinatal period. The effects of parity, however, are not the same in the two countries, with the drop of infant mortality rates for second children typical for Britain, only evidenced in rural areas in Poland and among mothers in the lowest educational category.

(b) Nosological Categories

To talk of "cause of (infant) death" is most usually to talk in terms of nosological categories. On this level it is a relatively straightforward matter to compare Poland and Eng/Wales, comparable data being published as WHO annual statistics. However, a historical dimension is lacking for, as Krzysztofowicz (1977:65) points out, before the seventies physicians in Poland were frequently not present at the death of infants in rural areas and thus unable to reliably certify cause of death. Nosological categories are of course medical categories and sociologists in Poland have not been oriented towards them, but then the whole question of infant mortality has been mediated there by demographers rather than sociologists. The demographers for their part rely heavily on the secondary classification of cause of death into endogenous (congenital abnormalities and certain conditions of the perinatal period) and exogenous (everything else). This comes close to a hereditary therefore unpreventible vs. environmental therefore preventible split, with an immediate aim - the reduction of deaths due to exogenous causes - becoming an ultimate goal and other deaths being relegated to an intractible endogenous category. Evidence

provided by the Perinatal Mortality Survey of 1958 and the British Births Survey of 1970 has, however, pointed to the environmental origin, and indeed occupational class-related nature of some of the factors involved in deaths due to congenital malformations, and to the lack of knowledge of aetiological factors which continues to make prevention in this area difficult if not impossible (Blaxter, 1981).

Closer examination of infant mortality rate according to cause shows what the Polish demographers do not refer to, that the quality of obstetric care is responsible for a fair percentage of deaths - although the Institute of Mother and Child (IMiDz) has consistently pointed to this factor (5). Its effect becomes clear when we compare the Polish and Eng/Wales figures in Table 1.4. For each disease category, raw numbers and rate per 100,000 live births are given, with the final column containing the ratio of the Polish to Eng/Wales rate. Looking down this column, there are three categories where the ratio of infant mortality rates diverges widely from the overall (uncorrected) ratio of 1.76. These are (1) infectious and parasitic diseases - 10.67, (2) birth trauma - 7.98, and (3) sudden infant death syndrome - 0.003 (6). Taking medical intervention in childbirth on its own terms, then, it can be seen in the first place that it is failing in Poland in its poor management of birth trauma. This category accounted for 9.3 per cent of infant deaths in Poland in 1980 as opposed to 2 per cent in Eng/Wales (See Table 1.5).

TABLE I.4: Infant mortality by cause (ICD9) in Poland and Eng/Wales, numbers and rates per 100,000 live births (1980).

	Poland		Eng/Wales		Pol.: E/W IMR
Total live births	692,799		656,234		1.76
Total infant deaths	14,739		7,899		
	Number	% 0000 l.b.	Number	% 0000 l.b.	
Infectious & parasitic diseases:	1428	206.12	126	19.2	10.67
Intestinal infectious diseases	393	56.73	45	6.86	8.27
Septicaemia	921	132.93	25	3.8	34.98
Whooping cough	5	..	6	..	..
Nutritional deficiencies	11	..	-	..	..
Diseases of the nervous system:	543	78.38	140	21.33	3.67
Meningitis	220	31.75	70	10.67	2.97
Diseases of the respiratory system:	1405	202.8	802	122.21	1.66
Pneumonia	1268	183.03	452	68.88	2.66
Influenza	23	..	6	..	..
Congenital abnormalities	3513	507.07	2113	321.99	1.57
Spina Bifida & Hydrocephaly	567	81.84	423	64.45	1.27
Congenital anomalies of heart & circulatory systems	1592	229.79	763	116.27	1.98
Certain conditions originating in the perinatal period:	6337	914.7	3133	477.42	1.9
Birth Trauma	1366	197.17	162	24.69	7.98
Hypoxia & Birth Asphyxia	2422	349.6	1562	238.02	1.47
Signs Symptoms & ill-defined conditions:	316	45.18	1035	157.72	0.28
Sudden infant death syndrome	3	0.43	1021	155.58	0.003
Accidents	-	..	164	..	..

Source: Extracted from WHO (1982), Table 9A, pp. 428-430.

The Short Report (HMSO, 1980: 104) notes that in Britain over 3/4 of infants dying for this reason are of normal birth weight, so there is some justification for viewing rate of death in this category as an indication of the mortality and morbidity producing aspects of modern medical childbirth, and the conclusion is that in Poland these aspects are greater. Secondly, infectious and parasitic diseases accounted for 9.7 per cent of infant deaths in Poland in 1980 (Table 1.5). Approximately 65 per cent of deaths in this category and over 6 per cent of all infant deaths were due to septicaemia. According to figures published by the IMiDz (1981: 15), the trend in septicaemia deaths has been an upward one, at least since 1975.

TABLE 1.5: Percentage of infant deaths in Poland and Eng/Wales due to selected disease categories (1980).

Disease category (ICD-9)	Poland	Eng/Wales
	%	%
Certain conditions in the perinatal period (45)	43	39.7
Congenital abnormalities (44)	23.8	26.7
Hypoxia and birth asphyxia (454)	16.4	19.8
Diseases of the respiratory system (31 & 32)	9.5	10.1
Infectious and parasitic diseases (01-07)	9.7	1.6
Birth Trauma (453)	9.3	2
Sudden infant death syndrome (446)	.0002	12.9

Source: Computed from WHO (1982), Table 9A, pp. 428-430.

> "This is undoubtedly related to the downright catastrophic state of the maternity and newly-born hospital base (where births have increased from 546,900 to 688,200 between 1960 and 1979), and this also goes for the state of equipment and hygiene (too few WCs and bathrooms) where overcrowding has reached such a point that women in confinement are lying in corridors and a maternity bed is in use for about 350 days in a year. This means that there is no way proper disinfecting can be carried out"

the IMiDz wrote in an upublished report (ibid: 14-16). Elsewhere - in its 1979 annual report - the Institute catalogues the shortages of equipment both sophisticated and mundane which hamper the functioning of the maternity and newly-born baby wards which it is its job to monitor (7). Clearly lack of investment in the material base of medicine is generating mortality and morbidity within hospital walls. While the question of dissatisfaction among women as to the kind of ante-natal and obstetric care they receive must now be addressed in Britain (cf. the Short Report), and while women's (unpublished) reports of childbirth in Poland are often horrendous, there is general endorsement of medical intervention in childbirth. Concern is understandably expressed at the material level - what women experience being viewed as something which just happens to be a poor version of basically a good thing.

(c) Socio-economic Categories.

In Britain, infant mortality statistics according to the occupational class of the father have been generated in the decennial censuses since 1911 when the Registrar General's classification

of occupations into social classes was first introduced to distinguish variations in death rates between occupational groups. Despite its limitations - there are dimensions of power and privilege which transcend occupational categories - this classificatory system has been widely and profitably used in studies seeking to discover the structural correlates of specific social behaviour and phenomena. Poland has no comparable classificatory system, and hence it is hard to obtain a comprehensive picture (i.e. one which includes all the major social divides) of the structural factors impinging on infant mortality and impossible to trace these effects over time. It is crucial that the Polish economy is divided, and statistical information collected, by sector rather than according to a person's location within a sector and between sectors. This in effect closes off any chance of determining the consequences of occupying a particular position within the social relations of production (among them and vitally, the consequences for health), of specifying particular interests, and of course of defending or pursuing those interests in an organised way. (It was Solidarity's prime tactic to replace vertical or sectoral trade union organisation with one which linked workers horizontally according to occupation in order to better pursue the interests of specific occupational groups - a feature found particularly unacceptable by the state authorities.) Prior to 1980, only some occupations, notably white collar and laying claim to professional status, had been able to organise, e.g. the Writers', Artists', Actors', Journalists', Lawyers' Unions, etc. The Polish marxist sociologist Jan Malanowski, briefly a member of the PZPR Central

Committee during the rise of Solidarity but subsequently removed, has pointed in a recent book to the importance of this sectoral division for hiding the Polish working class and the reality of their existence from view (Malanowski, 1981).

In Britain, a fair amount of data has been generated as a result of the routine classification of infant deaths by occupational class of the father. It is known that perinatal, neonatal, post-neonatal and infant mortality rates all vary (to differing extents) with occupational class, that the extent of class variation depends also on the nature of the disease and that, importantly, class differences have proved resistant to change, particularly in the years following the inception of the NHS (8), (see also Table 1.6). While explanations of this data have varied (9), and the precise mechanisms whereby occupational class, and through class material deprivation, affects infant mortality are unclear, the data themselves press for an overt focus on inequalities in health. This has in turn been associated with a professional concern with the mitigation of the effects of class (if not the questioning of the class basis itself of British society) involving the identification of target groups for health education, ante-natal care, screening, etc. - even if the individualistic solutions do not always fit with the structural factors underlying the production of ill-health (cf. Graham, 1979). The paradox is that despite the centrality of social equality at the level of ideology and rhetoric in Poland, statistics are not generated which might serve to monitor

TABLE 1.6: Perinatal mortality rates for legitimate single births by social class (Eng/Wales, 1950 & 1975).

Social Class	1950	1975	% decrease 1950-1975
I Professional	25.4	13.8	45.7
II Managerial	30.4	15.6	48.7
III Skilled	33.6	18.3	45.5
non-manual	-	16.0	-
manual	-	18.9	-
IV Semi-skilled	36.9	21.4	42
V Unskilled	40.4	27.0	33.1
All Classes	34.9	18.5	47

Source: Computed on basis of the Court Report (HMSO, 1976), Table E, p. 71; Adelstein, A.M., et al. (1980), Table 2, p. 23.

to what extent this professed goal is being achieved - quite the reverse. The subject of poverty is of course in itself a sensitive one - it took the authorities many years to finally give official recognition to the concept of the poverty line in 1981 (10), since which time it has lost all meaning with the onset of "crisis" and the dramatic all-round fall in living standards.

The categorisation of infant mortality data which is carried out as a matter of routine in Poland is that according to place of residence (rural/urban). This approximates to, but is by no means identical with the structural split between the private land-owning peasants and those employed in the socialised sector of the

economy. A traditional excess of infant mortality in rural areas has typically been explained in cultural rather than material or structural terms, i.e. in terms of "cultural lag" with mortality expected to gradually decrease with the permeation of urban culture and values to rural areas. References to the decay of the rural infrastructure, the specific demands and burdens imposed by under-invested farming and the separate social policy and health provisions for peasants are underplayed. This particular version of the victim-blaming approach rests in some degree on the traditionally low status of the peasant and the denial of peasant rationality and autonomy of culture (11). The situation has become more equivocal in recent years, however, with rural areas in nearly half of the 49 voivodeships now showing a lower infant mortality rate and national urban rates being more favorable for first-born children only (Kondrat, 1978).

A major study of the social determinants of infant mortality in Poland involving a sample of 6830 infant deaths occurring in 1974 was published by the Polish Central Statistical Agency (GUS) as an internal report in 1978 under the authorship of Władysław Kondrat. Infant deaths were presented according to level of income, standard of housing, level of mother's education and her social origin, yet the data was presented in such a way (raw numbers rather than rates) as to prevent the purported aim of the study - to establish the social determinants of infant mortality - from being realised. Some relative figures are given, however, and it is clear from these that infant mortality is concentrated within certain social groups.

Kondrat ascertains that 60 per cent of infant deaths occur in families living in 1-2 rooms, whereas only 37 per cent of the population as a whole does. 31.7 per cent of infant deaths took place in the lowest income group with an average monthly p.c. income of 1000 zł. or less, whereas 8 per cent of the general population are in this category. He also mentions in passing that "most of the families where an infant death had occurred were living in accommodation which did not have basic amenities" (water, gas or central heating) (ibid: 72). He concludes that "among the families studied there existed a cumulation of negative factors which hindered the proper development of infants and in extreme cases led to their death" (ibid). However, Kondrat seeks to avoid the structural implications of this conclusion by interposing a demographic variable. He argues, tenuously, that the infant mortality rate is higher among very young women, and among women over 35; both of these groups are then argued to be low income groups, in the first place because of a short employment record, and in the second because of the larger number of children likely to be in the family. Low income is seen as involving "less rational" eating habits. The choice of national figures for the purpose of comparison is also misleading. In the first place, statistical information on income as it is nationally collected excludes data concerning both extremes, together with undeclared secondary sources of income which tend not to accrue to unskilled manual workers and secondly both the national income and housing figures quoted include old age pensioners who are concentrated in the lowest income groups and tend to live in smaller homes. An alternative comparison with figures produced by

the 1975 annual Polish household budget study which excludes such pensioners produces a picture with starker contrasts, as is shown in Table 1.7.

TABLE 1.7: Percentage of all families and all infant deaths in selected income categories (Poland).

Monthly p.c. income (złoty)	under 1,200	under 1,500	over 3,000
Families*	4.7	11.3	37.7
Infant Deaths**	31.6***	52.1	7

* Based on a representative 1976 sample of 6915 (non-old age pensioner) family budgets.

** Based on a representative 1974 sample of 6830 infant deaths.

*** Refers to infant deaths in families with a p.c. monthly income of 1,000 złoty or less.

Source: Computed from Kondrat Wł. (1978) Table 16, pp. 124-5; Rocznik Statystyczny 1978, Table 12, p. 70.

It is, however, level of education which provides the main axis for this analysis of the social determinants of infant mortality. Education and how much of it a person has, has both structural and personal connotations - the author rejects the former and concentrates on the latter, level of education becoming an index of certain immanent, almost mystical qualities of a mother which in an undefined way influence her infant's life chances. A comparison of infant mortality rates (split into neonatal and post-neonatal rates) shows that among women who have not completed primary education there is a post-neonatal death rate seven times higher than among women who

have graduated from an institution of higher education (see Table 1.8 and Figure 1.2), which compares unfavourably with the British figures presented here where the variation in the post-neonatal rate among occupational classes I-V is 1:3 (12). Moreover, the comparatively small degree of overlap of rates between countries would suggest the operation of factors other than pure "education". But these dramatic figures do not take the author on to consider the structural correlates of education which include both income and standard of housing. A study carried out in 1980 showed, for example, that a low level of education is correlated with deprivation along several axes (most notably with whether a family is served by running water) (13). It is also important to note that the two lowest educational categories in Poland account for 45 per cent of live births - approximately twice the proportion of the semi-skilled and unskilled groups in Britain. As Alberman (quoted by Blaxter, 1981: 74) has noted "the major determinant of a country's overall (perinatal mortality) rate is the proportion of the population at socioeconomic disadvantage and the extent of their deprivation".

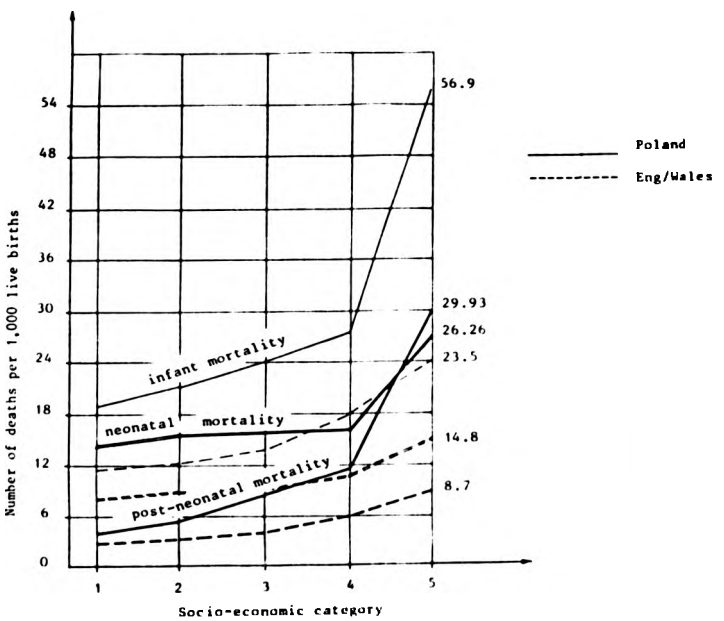
One is bound to conclude that what emerges is a studied avoidance of coming to terms with gross inequalities in health as measured by the infant mortality rate and the material inequalities which accompany them. This is clear if one compares the terms in which high pre-war infant mortality rates are explained in the same study, i.e. strictly materialist ones.

> **"A not insignificant role was played by the very difficult socio-economic conditions of most peasant and worker families. Low pay, often hopeless housing conditions, a lack of proper medical care and poor hygiene are only some of the factors exercising a**

TABLE 1.8 and FIGURE 1.2: Neonatal, post-neonatal and infant mortality rates per 1,000 live births by occupational class (Eng/Wales 1975), and by educational level (Poland, 1974*).

	Occupational Class of father	Neonatal Mortality Rate	Post-neonatal Mortality Rate	Infant Mortality Rate
Eng/Wales	I	8.0	3.0	11.1
	II	8.5	3.3	11.8
	III N	8.8	3.5	12.3
	III M	10.0	4.4	14.5
	IV	11.5	5.7	17.3
	V	14.8	8.7	23.5
Poland	Educational level of mother:			
	Higher	14.2	4.23	18.65
	Secondary	15.45	5.39	20.84
	Basic Technical	15.47	8.46	23.93
	Primary	15.89	11.36	27.25
	Incomplete Primary	26.26	29.93	56.19

* Polish data based on a national representative sample of 6830 infant deaths.



1 - Occupational Class I/Higher Education
2 - Occupational Class II/Secondary Education
3 - Occupational Class III/Basic Technical Education
4 - Occupational Class IV/Primary Education
5 - Occupational Class V/Incomplete Primary Education

Source: For Eng/Wales: Adelstein, A.M. et al. (1980), pp. 24-26.
For Poland: Kondrat, Wł. (1980), pp. 106 and 108.

> direct influence on the level of mortality in these families"
>
> (my emphasis - M.W.) (Kondrat, op. cit.:22)

Obviously an assumption of the inevitability of structural inequality is unavailable to Polish writers - ideologically, Polish socialism is, after all, based on the assumption that there is an alternative to capitalism and emerges from a materialist criticism of capitalist relations of production. Thus in order to write within the margins of acceptability, an author must be able to adopt at least two perspectives simultaneously which sometimes makes it hard to maintain a consistent logic.

Local studies provide an alternative source of information and much attention has been paid to the epidemiology of infant mortality in the textile town of Łódź with its large female proletariat and one of the highest rates of infant mortality in Poland. In the mid-seventies several of the larger factories created protected work areas for their pregnant manual workers. As an isolated and limited solution, this met with some success, but despite representations to the authorities, the provision of such facilities has not become regulated by law. Zdziennicki (1978) examined one hosiery factory and found that moving women out of harmful work conditions did affect the health of their infants, but nevertheless, and in spite of close medical surveillance of these pregnant manual workers, non-manual women remaining in their normal jobs throughout pregnancy still did better on some indices.

Summary

In sum, infant mortality data in Poland has generated less knowledge concerning existing inequalities in health than is the case in Britain, although it is clear that these inequalities do exist, and are probably greater than in Britain. There are also clear signs that poorer life and health chances are linked to deprivation in housing, income, education in both countries. While individualistic solutions (health education, expanded ante-natal care) are typically proferred to counteract the effects of a largely structurally determined phenomenon, the approaches differ in some respects.

(a) Polish writers who wish to conform to the demands made of them must be able to analyse on at least two different levels simultaneously - pre-war Poland and capitalist countries in stock Marxist and materialistic terms, Polish state-socialist reality in individualistic and victim-blaming terms. An assumption of inevitable inequality is replaced with an assumption of inevitable equality, which contradicts social consciousness.

(b) There is no tendency in Poland, as in Britain, to survey the distribution of health indices, or to identify categories of "under-utilisers", "non-attenders", etc, with the subsequent concentration of efforts, however relevant or irrelevant these might be, towards these groups. While official ideology, and indeed social consciousness, is overtly committed to the ideal of social equality, there is no consistent follow-up beyond the rhetoric.

(c) It is possible that focus on a strategic target group in itself implies a belief that nothing else of fundamental significance will change, is changeable or changing. Poland's failure to focus on target groups may thus be viewed as being tied in with the ideological stress on society in change, change in one sector implying change in all others. Certainly the steep decline in the infant mortality rate is accentuated and the assumption is that this will spread to all groups as and when specific cultural values associated with education diffuse through to all levels. On the one hand one has an assumed inevitability of state (the class divisions of society) and on the other the projected inevitability of process (progress towards an industrial socialist society) - both serve to deflect attention from structural factors producing ill-health.

Notes

1. Instrukcja Nr 5/75 Ministra Zdrowia i Opieki Społecznej z dn. 19.2.75 w sprawie opieki zdrowotnej nad populacją w wieku rozwojowym. III. Program poprawy opieki zdrowotnej nad populacją w wieku rozwojowym w latach 1975-1990 (Ministry of Health Instruction 5/75 concerning child health care. III. Programme for improvement of child health care 1975-1990).

2. Computed on the basis of statistics published in WHO (1982) Tab. 7A, p. 160 and 172.

3. A similar phenomenon has been discussed by Davis and Feschbach (1980) with reference to the USSR.

4. The definition of live birth which is current in Britain is that given by the WHO 9th edition of the International Classification of Diseases. This states that a live birth is one where there is "complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which ... breathes or shows other evidence of life" (HMSO, 1980: 5). The classification recommends inclusion in national statistics of all infants and foetuses over 500 gm, but recognises that the registration of very small babies (between 500 and 1000 gm) may complicate international comparisons, since some of the foetuses in this category may routinely be classified as abortions in some countries (ibid).

5. For a description of the functions carried out by the Institute and its location within the organisational structure of the Polish health service, see Chapter VI.

6. The low number of deaths reported in Poland under the classificatory heading of sudden infant death syndrome may be a product of recording

procedures. Polish physicians have speculated that the real number may be higher and may include home deaths which have been attributed to infections of the upper respiratory tract where no post-mortem examination has been carried out (Polska Akademia Nauk, 1978:229).

7. The 1979 IMiDz Annual Report points to the following shortages on newly-born baby wards:

> "the wards feel the keen lack of efficient incubators (Polish incubators, despite good maintenance, have many shortcomings) phototherapy lamps for cases of jaundice, good respirators, rubber bulbs for inflation, nappies, catheters, disposable needles and syringes, and indwelling intravenous cannulae. There is still an inadequate supply of saucepans and other kitchen utensils, dispensers for disposable hand towels, hot water bottles, and sterile containers for collecting urine. There are periodic shortages of blood in amounts smaller than 100 gm".
>
> (IMiDz, 1980a:135).

8. Cf. figures given in the Court Report (HMSO; 1976: Table E, p. 71). Blaxter (1981:39) quotes a range of findings, including those of the Perinatal Mortality Survey and the British Births Survey which indicate that social class differences are actually widening.

9. The various theoretical approaches to the explanation of the relationship between health and inequality are enumerated and described in the Black Report (Townsend and Davidson, 1982: 112 ff.).

10. The concept of the poverty line (minimum socjalne) was first "launched" in Poland in 1973 in a book by Andrzej Tymowski of the same title. Official recognition of the concept came only with the rise of Solidarity in 1981. See also Chapter III.

11. An early example of this approach is provided by a textbook for doctors undergoing post-graduate training in the organisation of

health care. The chapter on rural services opens as follows:

> "the disproportions in the rate of development of health care in urban and rural areas result primarily from general differences in cultural levels, knowledge, and the degree to which people have adopted hygienic habits"
>
> (Kożusznik and Kleczkowski, 1964: 165).

12. It should, however, be noted that OPCS material presented elsewhere indicates an occupational class ratio for infant mortality in Britain of 1:4.2 for boys and 1:5 for girls (Blaxter, 1981: 37).

13. More detailed reference to the findings of this study is made in Chapter III.

CHAPTER II

THE PUBLIC ECONOMY I: WOMEN AND PRODUCTION

Introduction

The mortality data which were presented in Chapter I have highlighted the importance of certain material factors on health - both at the level of medical intervention and in terms of the resources necessary for health which are available to individual families. On the one hand, material influences on health, the level of funding of health services and a population's standard of living, depend crucially on a nation's wealth (1). On the other, the structural arrangements through which wealth is generated must also be taken into account. That is why the present chapter undertakes to examine the place of women in the process of production in Poland and Eng/Wales.

There are several ways in which women's productive role may influence child health. First of all, there is the possibility that factors connected with the conditions of paid work may affect the health of a pregnant woman, and through her the developing foetus. It is not easy to establish the facts in this area since as researchers have observed, the relative effects of work and domestic conditions are hard to disentangle (Illsley and Billewicz, 1954) (2). Secondly, the paid work of women has consequences in terms of the balance which must be sought between the demands of time and energy made by employment, and the health work women have traditionally

done and are largely still expected to do within the domestic domain. Thirdly, as paid workers, women contribute to the family budget the financial resources which are vital for health.

It is with these last two aspects of paid work for women and the relation they bear to each other, that the present chapter is concerned. It is a relation which is not without its irony, as Graham (1984) has observed: those who are generally regarded as society's carers and health workers within the home have by the same token less access to health resources in terms of financial rewards for work done in the public domain. The perspective is one which is concerned with the role of particular political and economic strategies which sustain or modify the gender divisions which underly this situation: modernisation in Poland has taken place on ideological and political terms which contrast with the case in Britain, the abolition of private ownership and the mass employment of women being claimed as conditions sufficient for female emancipation.

The Employment of Women

Figures for 1980 show women to constitute 43.5 per cent of the economically active population in the socialised sector of the Polish economy, and 42.3 per cent of employees in employment in Britain (Rocz. Stat. 1981; Empl. Gtte., Aug. 1984). There are two main restrictions on the comparability of these indices. On the one hand,

the Polish figures - which are those normally quoted in international comparisons - exclude women who are economically active in the private farming sector. According to the Polish national census of 1978, women constitute 57 per cent of those engaged in productive work in this sector (3). Secondly, the British figure is substantially composed of women who work part-time, while part-time workers of either sex form a negligible proportion of the Polish labour force (4).

Underlying these limitations to the comparability of indices of economic activity is the different history of industrial and political change which each country has experienced: while Britain was the home of the industrial revolution, expansion of the economic base on a large scale did not come to Poland until well into the twentieth century, and then under the terms imposed by a state-socialist regime. During the inter-war period the rural population represented a stable proportion of the total population (5). Rapid post-war modernisation and the growth of industrial and urban centres has caused a steady decrease in this proportion, as is shown in Table 2.1.

TABLE 2.1: Rural population as a percentage of total population (Poland, 1946-1983).

Year	1946	1950	1955	1960	1965	1970	1975	1980	1983
Rural Pop (%)	66.1	63.1	56.2	51.7	50.3	47.7	44.3	41.3	40.3

Source: Polska 1946-1983, Table 2, p. 2.

Part of this urbanisation of the population was due to migration from rural areas, often from smallholdings (6). In addition to this, a significant and growing proportion of the rural population began to combine work on privately-owned farms with employment in industry. The numerical strength of the peasantry and the continuing drawing-off of peasants to the labour force in the socialised sector of the Polish economy means that the role of peasant tradition and culture, in particular, peasant attitudes to the family, work and the state, must be reckoned with if one is to give adequate meaning to the mass employment of women which has been an essential part of Poland's modernisation under state socialism. For as Scott and Tilly (1975: 42) have written, behaviour "is less the product of new ideas than the effect of old ideas operating in new and changing contexts".

The Inter-War Period

When Poland emerged as a re-created state after the first World War, the peasants represented the body of the nation. The structure of economic activity in Poland was therefore quite different from that in Britain, as the figures in Table 2.2 show.

The Polish census of 1931, on which the figures for Poland in the table below are based, treated women as productive agricultural workers in their own right, and indeed in 1931 they constituted one half of the agricultural labour force:

TABLE 2.2: Economic activity rates by sector and sex (%) (Poland and Britain, 1931)

Economically active	Agriculture		Manuf. Industry		Service Industries	
	Pol.	G.B.	Pol.	G.B.	Pol.	G.B.
Total labour force	75.3	12.2	11.8	38.8	12.9	49.0
Males	71.4	17.1	15.2	39.4	13.4	43.5
Females	84.0	1.5	5.1	38.2	10.9	60.3
Females as % of total labour force	49.9	3.4	21.8	28.0	40.5	37.2

Source: Floręcka, I. (1945), Table 49, p. 169.

In England and Wales, however, only 16 per cent of females aged 10 years and over were classified in 1921 as occupied in "agriculture, horticulture and forestry" (DOE & P, 1971). Farmers' wives were viewed by this time as belonging to one of "certain small groups whose status is marginal between 'occupied' and 'unoccupied'" (ibid.:206).

From the description Thomas and Znaniecki give of peasant life in Poland at the beginning of this century, it appears that the form of patriarchal power which was the norm was less harsh than that which had existed in Russia:

> "husband and wife are not individuals more or less closely connected according to their personal sentiments, but group members connected absolutely in a single way. Therefore the marriage norm is not love but 'respect' as the relation which can be controlled and reinforced by the family, and which corresponds also exactly to the situation of the other

> party as a member of a group and representing the dignity of that group. The norm of respect from wife to husband includes obedience, fidelity, care for the husband's comfort and health; from husband to wife, good treatment, fidelity, not letting the wife do hired work if it is not indispensible. In general, neither husband nor wife ought to do anything which could lower the social standing of the other, since this would lead to a lowering of the social standing of the other's family. Affection is not normally included in the norm of respect but it is desirable"
>
> (Thomas and Znaniecki, 1958:90).

Land, the authors point out, was not considered in terms of individual ownership, but as being under the temporary management of an individual, usually a male, and as belonging to the family. As in all peasant societies, the household was the basic social and economic unit. The position of the woman was high inside the family and within the circle of friends with whom the family maintained sociable contact, and this was true too for classes other than the peasantry (Sokołowska, 1976a, 1976b; Floręcka, 1945). However, lenient or not, in all cases the social order was a patriarchal one. What distinguished peasant women was the fact that they were "working partners in the family enterprise" (Scott and Tilly, op. cit.:49).

Political and civil rights were granted simultaneously to both men and women in 1918 in the new Poland. This had particular significance in the case of the peasantry, and provides another important point of contrast with the experience of the early developing Western nations, as Thomas and Znaniecki have again observed:

> "among the Polish peasants the sexes (are) equally dependent on each other, though their demands are of a rather limited and unromantic character, while at the same time this response is secured at the cost of a complete subordination of their personalities to a common sphere of group interests. When the development of personal interests begins, this original harmony is disturbed, and the disharmony is particularly marked among the immigrants in America, where it often leads to a complete and radical disorganisation of family life. In this respect the situation of the Polish peasants may throw an interesting light on the general situation of the cultivated classes of modern society. The difference between these two situations lies in the fact that among the peasants both man and woman begin almost simultaneously to develop personal claims, whereas in the cultivated classes the personal claims of the man have been developed and in large measure satisfied long ago, and the present problem is almost exclusively limited to the woman".
>
> (Thomas and Znaniecki, op. cit.: 82-83).

The consequences of this historical experience for the employment of women have been several. In the first place, denial of civil and political rights to Polish women in the 19th century had not become associated with an economic dependency on men, since the bulk of the female population had consistently been an indispensible productive force. Secondly, since personal claims were being pursued for the first time by both men and women, with the enfranchisement and emancipation of the peasantry as a whole, the idea of women as creatures of intrinsically lesser worth did not take hold to the same extent as in Britain. Thirdly, where agriculture depended so crucially on female labour, the ideology of the domestic setting as

"woman's place" had no economic foundations and would have been disastrous if implemented. The practical consequences this had outside agriculture included immediate legal parity with men, the lack of restrictions in education for women, the lack of barriers to specific occupations, the lack of dual salary scales according to sex, and the lack of formal sexual discrimination in the social security system. The meaning of work and of equality was transformed, for what Lapidus (1978: 337) has written of Russia holds true also for Poland, namely that the "the emphasis in Western liberal thought on the elimination of obstacles to full participation was replaced ... by an emphasis on the obligation to contribute; sexual equality came to mean an equal liability to mobilization."

Despite these differences, whose importance in both objective and subjective terms should be kept in view, the pressure of a fundamentally patriarchal social order remained just as strong in Poland as in Britain. The proportion of the non-agricultural labour force constituted by women was almost identical in 1931, being 31.4 per cent in Poland and 31.2 per cent in Britain (Floręcka, op. cit.: 171). Women were rather better represented among full-time students and in the professions than was the case in Britain (7), but generally, as Floręcka (ibid.: 190) concluded in her comparative study of women's employment in Poland and Britain during the inter-war years

> "it seems possible to state that the unwilling attitude of society to women in more responsible posts or still 'male' occupations proved effective in both countries with or without discriminating provisions."

The Post-War Period

Official records show that the first time the mobilisation of a female labour force in the socialised sector of the economy received detailed attention was during the initial stages of the six-year plan (1950-56). Exceedingly ambitious in its goals, the six-year plan required maximum mobilisation of labour force reserves - constituted wholly by women. A decree dated 21st July, 1950 cites the mobilisation of female labour as a conditio sine qua non for success of the plan:

> the "national economy must be assured an influx of the necessary numbers of new skilled and unskilled workers, technical and managerial personnel ... by the drawing in of women to production on a wide scale and by making it easier for them to take up gainful employment. The share of women in the total work force in the socialised sector must be increased to 33.5 per cent" (quoted by Kurzynowski 1979:60).

A motion on the subject of female economic participation which was passed in March of the same year by the PZPR Central Committee states in this connection that "an essential condition of the real liberation of women is that they should be allowed to link the obligations of bringing up children with creative productive and social work" (ibid.). In incorporating an explicit notion of a "dual role" for women, the six-year plan was of course subverting the constitutional principle of sexual equality which formed one of the foundation stones of Polish family law and in doing this, created a central contradiction in policy (8). The contradiction in British policy lay elsewhere, implicit in the propagation of an ideology which

relegated married women to the home, in a real world where female labour force participation was and is often indispensible to both the public economy and the domestic budget (cf. Wilson, 1977) (9). As long as the critical labour deficit in Poland lasted, exhortations for the mobilisation of female labour on these terms recurred. This need declined during the years 1955-58, when women began to have difficulties in finding employment - the trend to employment had gained too much momentum, while the level of investment had slackened. Since 1958, policy has been geared towards a moderate but steady increase in female employment.

In both Poland (the socialised sector) and Britain, female participation in the labour force has increased steadily during the post-war period. This is shown in Table 2.3 below.

TABLE 2.3: Women as a percentage of total labour force. (Poland (socialised sector) and Britain, (1950-1980)).

Year	Poland	Britain*
1950	30.7	-
1960	33.1	34.7
1970	39.6	37.5
1980	43.5	42.3

* comparable figures are not available for Britain for before 1959.

Source: For Poland: Polska 1946-1983, Table 17, p. 16.
For Britain: (1970-1980), Empl. Gtte August 1984, Table 1.1, p. 6; (1960), Empl. Gtte, March 1975, Table 4, p. 205.

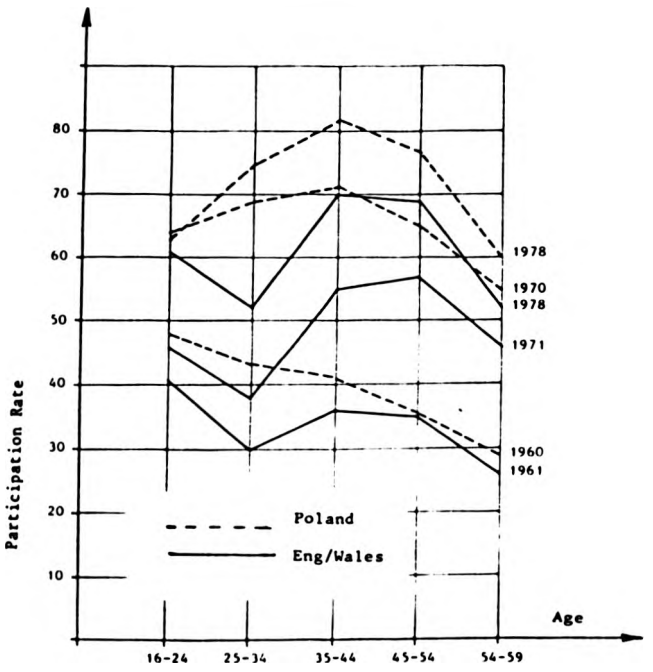
Similarly, in both countries the proportion of economically active women who are married has increased dramatically over this period. Before the second world war, the non-agricultural female labour force had in both countries been largely composed of single women, although widows played a greater role in this respect than was the case in Britain (Florecka, op. cit.). The activity rate among married women in the socialised sector of the Polish economy rose from an estimated 13 per cent in 1950 to 75 per cent in 1975, while as a proportion of economically active women in that sector, they increased from an estimated 18 per cent in 1950 to an estimated 65 per cent in 1975 (Kurzynowski, op. cit.: 21-22). Married women in Britain had been employed extensively throughout the second world war, and in 1951 a relatively high percentage remained in employment. The percentage of working women in that year who were married was thus relatively high at 40 per cent, and rose to 64 per cent in 1971 (Hakim, 1979: 11). Provisional Department of Employment figures for 1983 show that in that year 67 per cent of working women were married. In the sixties, the increase was greatest in the 35-59 year age group, while during the seventies, the major increases were among young married women aged 24 and under, as may be seen from Table 2.4 and Figure 2.1 below. The Polish figures show a more rapid and greater increase of participation among married women of prime child-bearing age, i.e. between 25 and 34 years. Figure 2.1 clearly shows the bi-modal work profile characteristic of married women's employment patterns in Britain, caused by married women leaving the labour market and re-entering it after their children have reached school age. No corresponding profile exists for Poland (10).

TABLE 2.4 & FIGURE 2.1: The labour force participation of married women by age (Poland & Britain, 1960-1978).

Age *	Poland			Britain		
	1960	1970	1978**	1961	1971	1978
16-24	48	64	63	41	46	61
25-34	43	69	75	30	38	52
35-44	41.5	71.5	81.5	36	55	70
45-54	35.5	65	75	35	57	69
55-59	29	55	60	26	46	52

* Polish totals represent an estimate based on the average of two 5 year categories

** Figures include women active in agriculture.



Source: For Poland: Kurzynowski, A. (1979), p. 24; 1978 Census figures provided by GUS.

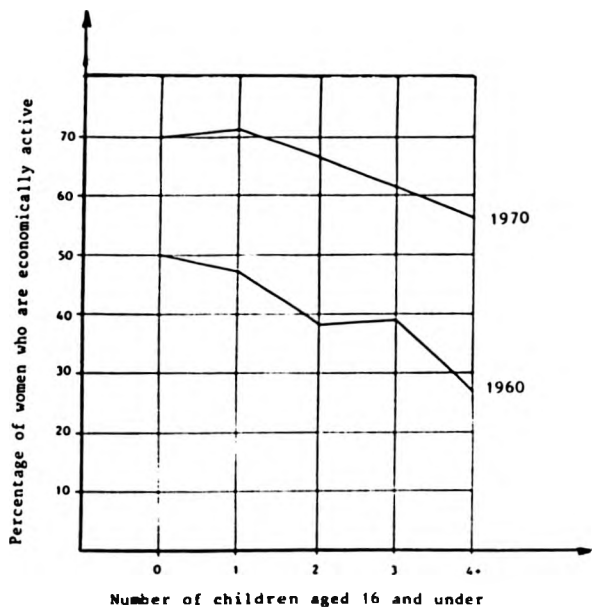
For Britain: Elias, P. (1980), p. 77.

This takes us on to consider in detail the effects of dependent children on the economic activity of women in each country.

The Employment of Women with Dependent Children - Poland

The increase in economic activity among married women during the sixties was particularly pronounced among women with children. This is shown in Figure 2.2 below.

FIGURE 2.2: Economic Activity Rates of Married Women by Number of Children (Poland, 1960 & 1970).



Source: Kurzynowski, A: (op. cit.), p. 29.

Whereas in 1960, 50 per cent of childless married women in Poland were in employment, as compared with 39 per cent of women with children, in 1970 these figures had increased to 70 per cent and 67 per cent respectively (Kurzynowski, op. cit.: 28). National census data do not include information concerning the economic activity of women according to the age of their youngest children, and the most recent survey concerned with this aspect of female employment was carried out in 1968. This study involved a national urban sample of 1,677 women aged between 21 and 47 years selected at random from the electoral register with a 92 per cent response; the results are shown in Table 2.5 below.

TABLE 2.5: Labour force participation of mothers by age of youngest child. (Poland, 1968).

Age of youngest child	No. of respondents	Number working	% working
0-3	431	274	63
4-7	357	249	70
8-14	588	421	72
15-18	128	82	64
19+	46	31	67
Total	1,550*	1,057	68

* The table excludes the 127 childless married women in the sample.

Source: Kurzynowski, A. (1979), p. 103.

Table 2.5 shows a slight depression in economic activity among married women whose youngest child is under 4 years of age. The study was conducted in 1968; if it were to be conducted today, this pattern would not be the same, for in the same year a system of child care

leave was introduced for working women initially one year's unpaid leave from employment (11). Women who previously would have withdrawn from the labour force were thus allowed to remain in it, although their productive activity was temporarily suspended. Kurzynowski was able to compare the continuity of employment over childbirth among women employed in the new industrial centre of Płock. Separate studies carried out in 1961 and 1974 showed that while in 1961 about 20 per cent of women withdrew from the labour force for an indefinite period following childbirth, in 1974, following the new legislation, about 35 per cent of mothers took advantage of unpaid child care leave and none withdrew totally from the labour force.

The Employment of Women with Dependent Children - England & Wales

Although the employment rates for women with dependent children, particularly young children, have risen steadily over the last twenty years, clearly the presence of such children still has a much greater effect on women's in employment in Britain than is the case in Poland (see Table 2.6).

TABLE 2.6: Employment rates for women with children by age of youngest child (Britain, 1961-1981).

Age of youngest child	1961	1971	1981
	%	%	%
0-4	11.5	18.7	25
5-10	24.2	38.5	57*
11-15	34.3	50.7	69**
All married women	29.7	42.2	48

* aged 5-9 years; ** aged 10+ years

Source: (1961 & 1971): Moss, P. (1980), pp. 25-26;
(1981): GHS 1981, Table 4.6, p. 94.

While the 1968 data for Poland shown in Table 2.5 show that 63 per cent of mothers whose youngest child was under 4 worked, in Britain the figure in 1971 was only 18.7 per cent, rising to 25 per cent in 1981. Although the largest discrepancy occurs in the case of very young children, there are also significant differences in the case of older children. Lack of more recent data for Poland rules out fuller comparison.

The number of dependent children a woman has is also more likely to influence her employment than is the case in Poland. In 1971, 45 per cent of women with a single child worked, as did 41 per cent of those with 2 children and 35 per cent of those with 3 or more (GHS 1981 : 95). These compare with rates of 71 per cent, 66 per cent and 61 and 56 per cent for Poland in 1970 (see Figure 2.2). By 1981, the British employment rates had risen to 53 per cent for women with one child, 50 per cent for those with 2, and 39 per cent for those with 3 or more (ibid.).

The recent survey on women and employment carried out by Martin and Roberts (1984) which accepts a wider definition of economic activity than that used in the General Household Survey, showed that in Britain, it is the age of a woman's youngest child, rather than how many children she has which is a crucial influence on her economic activity. This is illustrated by the figures in Table 2.7 below.

Economic activity rates in Britain during the 1950s grew fastest among married women with children of secondary school age, while during

the 1960s, the increase was greatest among women with primary school children (Moss, 1980). The increase for mothers of pre-school children during these decades was 6 and 45 per cent respectively (ibid.).

TABLE 2.7: Current economic activity by number of children under 16 and age of youngest child: all women with children under 16 except full-time students. (Britain, 1980).

Economic activity	Number of children under 16											
	1 child aged			2 children youngest aged			3 children youngest aged			4 children youngest aged		
	0–4	5–10	11–15	0–4	5–10	11–15	0–4	5–10	11–15	0–4	5–10	11–15
	%	%	%	%	%	%	%	%		%	%	
Working full time	11	16	32	4	17	28	5	15		8	14	
Working part time	16	49	44	23	49	48	22	43		10	41	
Total working	27	65	76	27	66	76	27	58		18	55	
'Unemployed'	5	5	4	3	3	7	2	6		4	9	
Total economically active	32	70	80	30	69	83	29	64		22	64	
Economically inactive	68	30	20	70	31	17	71	36		78	36	
	100	100	100	100	100	100	100	100		100	100	
Base	*388*	*230*	*478*	*435*	*429*	*201*	*165*	*165*	*28**	*50*	*44*	*3**

** Base too small to show percentages*

Source: Martin, J. and Roberts, C. (1984), Table 2.7, p. 14.

During the seventies, however, employment rates among mothers of pre-school children increased twice as fast as for any other group (ibid.).

It has to be noted that much of the post-war growth in the employment of married women in Britain has been due to more part-time working. Between 1961 and 1981 the proportion of all mothers in full-time employment rose by only one percentage point, from 14 to 15 per cent (Moss, 1980; GHS 1981). In 1961, part-time workers accounted for 12 per cent of all mothers, rising to 26 per cent in 1971 and 34 per cent in 1981 (ibid.). By 1981, 69 per cent of all mothers had part-time jobs and mothers represented 63 per cent of all female part-time workers (GHS 1981) (12). In Martin and

Roberts' (1984) study, only 15 per cent of wives worked the same or longer hours than their husband.

Part-time employment, is, moreover, significantly related to downward occupational mobility.

> "(A)mong 51% of women who had changed occupational level on returning to work after childbirth, 37% had moved downwards; only 14% returned to a higher level occupation. Downward mobility was strongly associated with returning to part-time work: 45% of those who returned part-time returned to a lower level occupation compared with 19% of those who returned full-time. The association between downward occupational mobility and part-time working held even when variations in the length of time out of the labour force for childbirth were allowed for"
>
> (ibid.:152).

Thus, the effects of childbirth have long-term effects in terms of women's earning power. Using the data provided by Martin and Roberts's survey, Joshi has estimated that family formation depresses a woman's lifetime earnings on average by between 25-50 per cent (ibid.:99). The matter of relative earnings is considered in a later section.

Occupational Segregation

The concentration of female labour within certain sectors of the economy, and within the lower grades of sectors is a central feature of the organisation of the British labour market, as Hakim (1979) has indicated. Horizontal and vertical segregation persist in Poland as in Britain, despite constitutional guarantees of sexual

equality in the one case, and the 1975 Equal Pay and Sex Discrimination Acts on the other. In both cases women tend overwhelmingly to be confined to jobs with low prestige and low pay; the remainder of this section will consider evidence of the extent of such segregation in each case, and its consequences in terms of earnings differentials between male and female employees.

There are certain methodological difficulties involved in the estimation of the degree of horizontal segregation within a nation's labour force. In the first place, the degree of segregation elicited is highly dependent on the unit of analysis (ibid.). The bigger the unit, the more segregation it is likely to conceal. Thus, the degree of segregation established on the basis of economic sector is necessarily an underestimation since it ignores the way in which women are concentrated in certain occupations, for example in clerical work, within sectors. The extent to which horizontal segregation is revealed at this level therefore depends on how sectors of the national economy are classified. Tables 2.8 and 2.9 present the percentage of female labour in each of the main economic sectors in Poland and Britain. Congruence exists only in certain categories, with women being underrepresented in trade, state administration and finance and insurance. Other categories do not correspond; for example, industry orders 2-19 for Britain are subsumed under the single heading of "industry" for Poland, while order 25 - "professional and scientific services" includes both health and education. This imposes limitations on the comparability of the data.

TABLE 2.8: Female participation rate* by industry (Britain, 1961 & 1978)

* per 1,000 employed.

Industry	1961	1978
Agriculture, etc	203	244
Mining, quarrying	28	41
Food, drink, tobacco	418	400
Coal, petrol products	130	111
Chemicals	302	287
Metal manufacture	114	115
Mechanical engineering	163	157
Instrument engineering	376	354
Electrical engineering	364	370
Shipbuilding	46	75
Vehicles	137	122
Metal goods	333	280
Textiles	546	453
Clothing, etc	704	728
Bricks, pottery, etc	226	240
Timber, etc	196	193
Paper, print, publishing	346	325
Other manufactures	397	363
Construction	48	83
Gas, electricity, water	113	200
Transport, communication	144	180
Distributive trades	518	560
Insurance, banking, etc	450	514
Professional & scientific services	653	683
Miscellaneous	551	587
Public administration	303	387
Total	348	412

Source: Computed from Elias, P. (1980), Tables 9 & 10, pp. 71-72.

TABLE 2.9: Female participation rate* by branch of economy (Poland, 1950-1983).

* per 1,000 employed in the socialised sector.

Branch of economy	1950	1955	1960	1965	1970	1975	1980	1983
Industry	294	303	304	321	354	392	386	366
Construction	110	124	102	136	161	180	196	185
Agriculture	204	208	210	212	245	264	279	270
Forestry	65	63	126	147	158	179	195	174
Transport & Communication	150	151	149	177	212	244	265	274
Trade	497	515	549	601	676	714	715	707
The Communal economy) Housing & non-material) communal services)	304	314	284	334	368	298 448	286 446	262 432
Science & Technology)			419	407	455	451	462	473
Education)	508	568	655	700	717	726	747	752
Culture & The Arts)			487	508	566	599	607	606
Health & social welfare)	756	759				804	806	798
Physical culture & recreation)						590	569	552
State administration & administration of justice	380	389	400	481	538	573	610	608
Finance and insurance	598	577	610	679	722	793	827	837
Total	307	322	331	360	394	423	435	437

Source: Polska 1946-1983, Table 17, p. 16.

There are also problems involved in collecting data on occupational segregation at the level of the enterprise. In Poland it is probably true to say that no such studies have been carried out. In Britain a 1973 study carried out by Hunt showed that 18 per cent of establishments did not employ men and women on the same work, with segregation most marked in managerial or supervisory and skilled manual jobs, while another 1979 study found that of establishments surveyed, 45 per cent had no women in them and 21 per cent had no men, making most jobs single sex (Martin and Roberts, 1984). Occupational segregation is a dynamic process, as may be illustrated by the example from the rapidly developing field of computing. In a survey conducted in 1973, it was found that in one computing company

there were no women in management and 5 women and 100 men in computing consultancy jobs, but at the level of programmer or system analyst, the survey found the ratio between men and women to be approximately 8:3 (Henriques, 1984).

> "A subtle pattern of job segregation has evolved. As the importance of a particular task declines in terms of necessary skills and status, the number of women employed to fulfil that task rises. Apparently, a profession in a male-dominated industry is opened to women only after it has lost its kudos" (ibid.)

Martin and Roberts (1984) used a third approach in their attempt to measure the extent of occupational segregation in their 1980 survey. This was based on the responses of the women taking part as to whether any men at their workplace were doing the same kind of work as them. This provided a measure of job segregation actually experienced by women at work. Of those who were able to compare themselves with others, 63 per cent worked only with other women while 37 per cent worked where both men and women did the same kind of work as they did. Occupational segregation was lowest in occupational classes I and II, and also in semi-skilled occupations, while in manual occupations it occurred for 70 per cent or more of women. On the whole, part-time workers experienced more job segregation than full-time workers. The approach also allowed the evaluation of occupational segregation experienced according to occupational order and industry group. The results are shown in Tables 2.10 and 2.11 below. Table 2.11 shows a higher degree of segregation in manufacturing than in the service industries for full-time but not part-time workers.

TABLE 2.10: Proportions of full and part-time working women in different occupational orders who work at a place where only women do the same work. (Britain, 1980).

Occupational order	Full time		Part time		All women working with others	
	% in 'women only' jobs	*Base*	% in 'women only' jobs	*Base*	% in 'women only' jobs	*Base*
Managerial general	–	–		–	–	–
Professionals supporting management	36%	*33*		*3**	36%	*36*
Professionals in health, education and welfare	32%	*284*	41%	*37*	35%	*421*
Literary, artistic and sport		*9**		*7**		*16**
Professionals in engineering and science		*13**		*4**		*17**
Other managerial	54%	*68*		*11**	56%	*79*
Clerical	62%	*727*	78%	*255*	66%	*982*
Selling	53%	*116*	64%	*180*	60%	*296*
Security		*10**		*3**		*13**
Catering, cleaning and hairdressing	71%	*163*	78%	*539*	77%	*702*
Farming and fishing		*11**		*15**		*26**
Material processing (excluding metal)		*26**		*19**	57%	*45*
Making and repairing (excluding metal)	82%	*109*	87%	*39*	83%	*148*
Metal processing, making and repairing	60%	*52*		*19**	58%	*71*
Painting, assembling and packing	79%	*119*	70%	*40*	77%	*159*
Construction and mining		*1**		–		*1**
Transport		*19**		*8**		*27**
Miscellaneous		*3†*		*2**		*5**
All women working with others	**58%**	*1,765†*	**70%**	*1,282†*	**63%**	*3,047†*

**Base too small to show percentages*
†Includes 3 cases whose occupational order was not known

Source: Martin, J. and Roberts, C. (op. cit.), Table 3.11, p. 27.

TABLE 2.11: Proportions of full and part-time working women in different industry groups who work at a place where only women do the same work. (Britain, 1980).

Industry group	Full time		Part time		All women working with others	
	% in 'women only' jobs	*Base*	% in 'women only' jobs	*Base*	% in 'women only' jobs	*Base*
Food and drink and tobacco	57%	*70*	68%	*38*	61%	*108*
Textiles, clothing and footwear	82%	*111*	82%	*44*	82%	*155*
Engineering and metal manufacture	71%	*191*	72%	*60*	71%	*251*
Other manufacturing	70%	*122*	72%	*39*	70%	*161*
Total manufacturing	71%	*494*	73%	*181*	72%	*675*
Distribution	63%	*245*	65%	*254*	64%	*499*
Professional and scientific services	51%	*450*	71%	*408*	61%	*858*
Insurance, banking and public administration	42%	*281*	68%	*110*	50%	*391*
Other services	56%	*276*	73%	*305*	65%	*581*
Total services	53%	*1,252*	70%	*1,077*	61%	*2,329*
Primary industries		*14**		*22**	47%	*36*
All women working with others	**58%**	*1,765†*	**70%**	*1,282†*	**63%**	*3,047†*

**Base too small to show percentages*
†Includes 7 cases whose industry was not known

Source: Martin, J. and Roberts, C. (op. cit.), Table 3.12, p. 28.

Hakim (1979) has shown that vertical segregation in England and Wales has declined only slightly during this century. Using job specifications and data in census reports for England and Wales, she has calculated for the years 1901-1971 the degree of over-representation of females in disproportionately female occupations (where their rate of participation is above the national average), and under-representation in disproportionately male occupation (where the rate of female participation is below the national average). The results are summarised in Table 2.12 below.

TABLE 2.12: Index of over- and under-representation of females in disproportionately female and male occupations (desegregated ideal = 1.00), 1901-1971 (Eng/Wales).

Year	Ratio of observed to expected female participation rates	
	disproportionately female occupations	disproportionately male occupations
1901	2.7	0.18
1911	2.4	0.20
1921	2.3	0.19
1931	2.4	0.21
1951	2.2	0.23
1961	2.1	0.27
1971	2.0	0.27

Source: Hakim, C. (op. cit.), Tables 14 and 15, pp. 26 and 27.

These figures take into account the changing rates of female economic participation and show a slight decrease in horizontal segregation in England and Wales during the first 70 years of this century.

Hakim notes that this small shift to desegregation has been caused by men entering formerly female areas of employment, which is not entirely consistent with the Polish situation, where there has been a partial movement by women into formerly male areas.

Vertical movement has also been very slight. Bain and Rice (1972) have categorised occupational groups according to grade of occupation using British census data, allowing a historical comparison of the proportion of women in each of ten grades to be carried out. Their figures for 1911-1961 are presented alongside figures for 1971 derived by Hakim (op. cit.) in Table 2.13.

TABLE 2.13: Under- and over-representation of women in major occupational groups (Great Britain, 1911-1971).

	1911	1921	1931	1951	1961	1971
Employers & managers	0.64	0.69	0.66	0.65	0.63	0.68
White collar workers :	1.01	1.27	1.20	1.37	1.37	1.31
(a) managers & administr.	0.67	0.58	0.44	0.49	0.48	0.59
(b) higher professionals	0.20	0.17	0.25	0.27	0.30	0.27
(c) lower professionals & technicians	2.13	2.01	1.97	1.74	1.57	1.43
(d) foremen & inspectors	0.14	0.22	0.29	0.44	0.32	0.36
(e) clerks	0.72	1.51	1.54	1.95	2.01	2.00
(f) salesmen & shop assistants	1.19	1.48	1.25	1.68	1.69	1.64
All manual workers:	1.03	0.95	0.97	0.85	0.80	0.81
(a) skilled	0.81	0.71	0.71	0.51	0.43	0.37
(b) semi-skilled	1.36	1.37	1.44	1.24	1.21	1.27
(c) unskilled	0.52	0.57	0.50	0.66	0.69	1.01

Source: Hakim, C. (1979), Table 17, p. 28.

Women's share of top jobs, as defined in Table 2.14, was minimal in England and Wales in 1971 and little higher than in 1901. A significant increase has however been observed among doctors, with the proportion of women in the medical profession rising from 2 per cent to 20 per cent between 1901 and 1971.

TABLE 2.14: Women's share of top jobs. (Britain, 1911 & 1971).

Per cent of women among total in each group	1911	1971
Doctors	2	20
Accountants	0.2	3
Architects and town planners	0.08	5
Judges, barristers and solicitors	0	6
Ministers, MPs and Senior Government*	5	12
Local Authority Senior Officers*	5	15

* These 2 groups were not precisely defined in the 1911 occupational classifications and included officers below senior grades.

Source: Hakim, C. (1979), Table 20, p. 34.

Women have historically been better represented in the professions in Poland, particularly in the medical profession, as was mentioned earlier in the chapter. While about one third of doctors in Poland in 1931 were women, by 1980 this proportion had risen to 52 per cent. Nevertheless, Sokołowska (1976b) points out that within the Ministry of Health and Social Welfare, no woman fills the post of minister, vice-minister or department head. Women are also better represented in senior management and administration than is the case in Britain. Figures published by the International Labour Office for 1970/71, show that women constituted 8 per cent of this grouping in Britain,

but 27 per cent in Poland (ILO, 1976). More recent data for Poland show this participation rate to have risen to 31 per cent (see Table 2.15).

TABLE 2.15: The percentage of women in managerial positions by occupational grouping (Poland, 1977).

Occupational Grouping	% of women
1. Total (except for foremen/women)	31.0
2. Top state officials	5.6
3. Heads of departments in central & local state administration, and major craft cooperatives	35.8
4. Heads of federated enterprises and their equivalent, and their internal sections for the organisation of basic activities*	16.3
5. Managing directors of industrial, construction and their internal sections for the organisation of basic activities	7.8
6. Managing directors of horticultural, fishery & agricultural service enterprises and their internal sections for the organisation of basic activities	8.2
7. Heads of transport & communication and their internal sections for the organisation of basic activities	21.8
8. Heads of department, domestic & foreign trade, catering and their internal sections for the organisation of basic activities	60.5
9. Institutional heads, in higher education & research establishments and their internal sections for the organisation of basic activities	17.9
10. Institutional heads in culture & the arts, and their internal sections for the organisation of basic activities	60.8
11. Institutional heads in health care and their internal sections for the organisation of basic activities	65.5
12. Institutional heads in the administration of justice and their internal sections for the organisation of basic activities	23.6
13. Institutional heads in finance and insurance, and their internal sections for the organisation of basic activities	52.6
14. Vice-managing directors of federated enterprises and equivalent	14.1
15. Head book-keepers	67.3
16. Heads of organisational, technical, economic, personnel and administration sections (apart from those concerned with "basic activities")	34.3
17. Master-craftsmen/women	6.8
18. Heads of service establishments not mentioned above	39.6
19. Foremen/women	10.8

* these internal sections may be regarded as roughly synonymous with the Party cells found in all state institutions.

Source: MPPiSS figures reproduced in Dach, Z. (1980), Table 20, pp. 98-99

However, this rate varies and women still occupy well under 10 per cent of the top jobs in the state and in industry.

The most detailed information on vertical segregation in Poland is provided by the breakdown by sex and grade of the numbers of academic teachers employed in institutes of higher education in that country. Assuming that the positions from full professor to assistant represents a hierarchy, a particular career structure, it is possible on the basis of annually published national statistics to observe how the distribution of women in this hierarchy has changed over time. Table 2.16 shows the percentage of women in academic teaching positions between 1960/61 and 1981/82, taking into account the overall increase in female labour force participation rates over this period.

TABLE 2.16: The percentage of female academic teachers in institutes of higher education (Poland, 1960/61 - 1981/82).

Year	Total part. rate		Full Professor	Assoc. Professor	Docent	Adjunkt	Senior lect/ lecturer	Senior Assistant	Assistant
	Nation.	Acad.							
1960/61	33.1	26.4	5.5	8.4	14.4	22.1	10.6	32.0	38.6
1970/71		30.7	6.6	9.7	13.3	32.8	26.6	34.1	37.2
1980/81		35.1	8.0	12.8	17.6	33.1	38.6	38.8	41.3
1981/82	44.2	35.3	6.8	13.5	18.2	33.2	41.2	38.6	42.4
% change 60/61-81/82	+33.4	+33.9	+25.5	+60.8	+26.3	+50.1	+287.1	+20.7	+9.7

Source: Computed from Rocz. Stat. 1980, Table 31, p. 413, and Rocz. Stat. 1982, Table 29, p. 413.

The table shows a steady increase in the percentage of academic teachers in Poland who are women. The increase mirrors the growth in the proportion of women in the labour force as a whole, but is not a uniform one when viewed in detail. The greatest growth has been in the positions of lecturer and senior lecturer, while at the top of the hierarchy women remain a tiny proportion of full professors. The pattern of increases over time suggests that several factors are at work. Women have moved en masse into lecturing jobs, which are the lowest positions in academic teaching with tenure where a doctorate is not a formal requirement. These posts do not form part of a career structure, lecturers not moving beyond senior lecturer grade. It is possible that women graduates have found that this job in terms of the working hours involved and security offered, is one which fits in well with their domestic tasks. Women are increasingly holding academic teaching positions where a PhD is required (adjunkt), but are less likely to undertake the higher habilitation qualification (docent). All but a handful are excluded from professorships, which are conferred by nomination and which do not necessarily require a habilitation degree.

Official employment figures for Britain do not provide a comparable breakdown of data concerning academics, but survey figures for 1969 and 1979 have revealed participation rates at different grades of the academic hierarchy as shown in Table 2.17 below.

TABLE 2.17: Women as a percentage of full-time, non-clinical academic staff (UK, 1969; GB, 1979).

Year	Total	Professor	Reader/Senior lecturer	Lecturer	Other
1969 (UK)	9	1	6	11	22
1979 (GB)	10	3	6	13	-

Source: Compiled from: Blackstone, T. and Fulton, O. (1975), Table 1, p. 263; EOC (1982a), Table 4a, p. 5.

While Tables 2.16 and 2.17 cannot be compared in strict terms, they do indicate that around 1980 over all female academic participation rates were substantially higher in Poland than in the UK (approximately 35 per cent as opposed to 10 per cent). Notwithstanding this global difference, in both cases stringent vertical segregation was a major feature of female employment in this sector.

Relative Earnings

The average weekly or monthly earnings of British women in full-time work and of Polish women employed in the socialised sector of the economy form a remarkably similar proportion of the earnings of their male counterparts. Polish national data for 1970 show that women earn on average 2/3 of male earnings, although this fraction depends also on level of education (see Table 2.18). More recently, Lapidus (1978) and Zarzycka (1978) have mentioned similar percentages.

TABLE 2.18: Average net monthly wages in złoty by sex and education (Poland; September, 1970).

Sex	Total	Educational Level				
		Incomplete Primary	Primary	Basic Vocational	Secondary	Higher
Men	2681	2347	2584	2608	2730	3690
Women	1795	1547	1693	1673	1890	2739
Women's earnings as % of men's	67.7	64.7	65.5	64.0	69.2	74.2

Source: GUS Household Budget Survey figures reproduced in: Oleksiewicz, B. (1976), Table 21, p. 29.

Furthermore, female manual workers constitute an occupational group with a uniformly depressed earning potential. In a survey carried out in 1969, Bejnarowicz and Markowska (1974) found that while 69.2 per cent of men with higher education and 37.1 per cent of male manual workers earned over 2,500 zł. per month, 23 per cent of female graduates and only 5.5 per cent of female manual workers earned at this level. Figures for Britain provided by the 1983 New Earnings Survey show that on average the weekly earnings of women in full-time employment are 65 per cent those of men, while their gross hourly earnings are 72 per cent of male earnings (Department of Employment, 1983).

However, Polish women contribute more on average to the family budget than is the case in Eng/Wales, (particularly where there are children in the family). This is illustrated in Table 2.19; the Eng/Wales figures are based on the 1974 Family Expenditure Survey, while those for Poland are based on the 1975 GUS Household Budget Survey.

TABLE 2.19: Women's earnings as a percentage of family income by number of children (Poland, 1969; Eng/Wales, 1974).

Number of children	Women's Earnings as % of Family Income	
	Poland	Eng/Wales
0	45.9	31
1	39.0	21
2	38.1	20
3+	37.6	18-19
Total	39.4	25

Source: For Poland: Zarzycka, Z. (1978), Table 7, p. 102;
For England & Wales: Hamill, L. (1979), Table 9, p. 17.

Clearly women's earnings are less depressed by the presence of the children in the family than is the case in England and Wales. In both cases it is the very presence of children rather than their number, which has the main effect on earnings. The table refers only to economically active women in each country. Since part-time work is not one of the options open to women following childbirth in Poland, the drop in earnings which are experienced there following childbirth is probably due to a shift into lower-paid employment, probably into jobs which are easier to maintain alongside child-rearing responsibilities.

Considering that women's gross hourly earnings are now over 70 per cent those of men in Britain, their low contribution to family income must largely be due to number of hours worked, in particular to the tendency for women not to work overtime, and to work part-time. Moreover, as we have already seen, a return to

part-time work following childbirth is associated with downward occupational mobility. Because of the concentration of part-time workers in particular occupational groups, their gross hourly earnings are substantially lower than those of their full-time counterparts (Martin and Roberts, op. cit.).

The mechanisms which operate to keep down women's wages in countries where legislation now exists stipulating the equal treatment of women as potential and actual employees are necessarily complex. Differences in qualifications may be one immediate reason, but of overwhelming importance is occupational segregation, present in both Poland and Britain, which rests on deep-seated notion of what is women's work inside and outside the family.

In Britain, but not in Poland, part-time working is responsible not only for low pay, but also for lack of eligibility for a wide range of insurance and occupational benefits (ibid.). In Poland, the system of maternity and child care leave guards against downward occupational mobility following childbirth. However, there does exist a wage scale system (widełki płac) for certain jobs, which in effect serves to increase male wages relative to those of women.

> "The assumption that level of pay within the scale has to be fixed according to individual qualities of an employee such as initiative, interest in the work, results, creates the opportunity for wage discrimination against women"
>
> (Oleksiewicz, 1976:60).

Thus Oleksiewicz found that in one large enterprise, male departmental heads on average earned more than women in comparable jobs,

although they were not better qualified and had not been longer in the job. These findings are summarised in Table 2.20.

TABLE 2.20: Average monthly earnings and length of employment of departmental heads in the Włocławek Ceramic Enterprise (WZCS) (1975).

Those with higher education	Women	Men
Average monthly earnings in złoty	4,966.6	5,300
Average length of employment in WZCS (years)	3.66	3.66
Those with secondary education		
Average monthly earnings in złoty	4,125	4,543
Average length of employment in WZCS (years)	14.2	10.8

Source: Oleksiewicz, B. (1976), Table 2.8.

Dual labour markets operate in both countries. Florczak-Bywalec (1975), in her study of the State Employment Agency in Łodż has written that "in practice we have two completely separate labour markets: a labour market for women and a labour market for men. Jobs are advertised according to sex" (ibid: 24). Male labour is preferred, while women constitute a labour reserve, their elasticity as a labour force being negatively correlated with level of education. Moreover, jobs which are in substance identical but advertised separately for women and for men may carry different wage levels within the "widełki płac" scale accordingly, and Florczak-Bywalec gives an example of this. Where demand for labour falls below supply, women find it more difficult than men to get a job; when there is a deficit of male labour, jobs previously advertised "for men" are re-classified and advertised "for women" (ibid.). In an analysis of files for the period

from 1960 to 1973, she found that, in a town with a traditional female proletariat currently constituting 50 per cent of the labour force, two thirds of the vacancies advertised during the period were for men. An average of two thirds of the vacancies carried a wage less than 1,000 złoty per month. However in 1970, for example, 3/4 of the vacancies in this lowest wage category were advertised for women, while women's jobs represented only 10 per cent of those carrying a wage of 2,000 złoty or more per month.

While on the subject, it is interesting to note that paid child care leave, which might realistically have been expected to cause increased numbers of women to temporarily withdraw from the labour force, was introduced at a time, during the height of the economic crisis of 1981, when widespread unemployment seemed an immediate prospect for the country.

The immediate formal mechanisms by means of which women become concentrated in low-status and low-paid jobs rest on deep gender divisions not easily changed by law.

> "The discord between the legal and conventional model of behaviour has several consequences. These are seen in the reluctance to promote women, in their allocation to lower positions despite equivalent qualifications, in the widespread conviction that for women paid employment is a sad necessity, and finally in the attitudes of women themselves"

writes Oleksiewicz (op. cit.: 29). Elsewhere, in a study of women in managerial positions in industry carried out in Łódź, Dzięcielska-Machnikowska and Kulpińska (1967) quote the response of a male managing

director of one industrial enterprise: "(w)e love and respect a women but never obey her" (p. 92). For the authors, this comment encapsulates an impasse in female employment which has been reached as a result of "the divergence of cultural patterns concerning mutual relations between men and women in private life and in the work environment" (ibid.). It also encapsulates the ease with which so-called gallantry can slip into a straightforward patronising attitude.

It is, however, true to say that the position of women within the family is high, enhanced by cultural tradition, an historical productive role, and currently by a political environment which has resulted in a devaluation of the public domain (13). It would also be true to say that it is on the basis of her position as wife and mother that a woman continued to be primarily accorded respect in Polish society. In an interesting pilot study involving 50 respondents, Reszke (1978) found that the factors which were regarded as determining a woman's status were quite different from those thought to determine the respect accorded to her, and in both cases differed from those thought to determine the status and respect accorded to men. A woman's status was seen as primarily dependent on the job, seniority and earnings of her husband, and only secondarily as dependent on the educational qualifications of the woman herself, while respect was "primarily accorded women for performing their family roles properly or for possessing qualities allowing these roles to be performed" (p. 93).

The factors which contribute towards women's high standing contribute also to the widespread conviction which has emerged in

research that in Poland sex is not an important source of inequality (cf. Koralewicz-Zębik, 1984: 227). The currency of female emancipation has thus become devalued, being identified with a double work burden (14). Since status is still commonly ascribed to women on the basis of marriage, and respect primarily accorded on the basis of domestic roles, it is withdrawal from productive activity rather than domestic tasks which is commonly seen as the most desirable but not always practicable resolution of the double burden.

To conclude this section, one can do no better than to quote from Floręcka, whose words written 40 years ago with reference to the inter-war period still hold true today:

> "(h)ere the most important factor of women's discrimination is at work: the attitude of society, or at least of that part of society which had at that moment a final say.
> Society still has not yet grown accustomed to women filling posts on an equal footing with men and unofficial discrimination was carried out in both countries. It was like a kind of conspiracy, very peculiar, spontaneous and unorganised, of men who disliked women in superior positions. Such an attitude handicapped women seriously, being difficult to overcome because it could not be done by an Act of Parliament"
>
> (Floręcka, op. cit.: 188).

Women in Agriculture

In this section we turn to the productive role of women in agriculture. As was mentioned at the outset of this chapter, the

persistence of a large agricultural labour force is a feature which distinguishes economic activity in Poland and Britain and places certain constraints on the comparability of national data. Of necessity, what follows is an analysis of the Polish situation only.

The proportion of the Polish population deriving its living solely or mainly from agriculture has been decreasing since the first official statistics for Poland were published in 1921. This changing national and rural social structure is reflected in the post-war figures presented in Table 2.21.

TABLE 2.21: The percentage of the population deriving its income from agriculture (Poland, 1950-1983).

Year / Percentage of:	1950	1960	1970	1978	1983
Total population	47.1	38.4	29.8	23.4	21.3
Rural population	77.9	69.5	57.9	48.7	-

Source: Rocz. Stat. 1980, Table 13, p. 38;
Polska 1946-1983, Table 4, p. 3.

Before agrarian reform in 1946, the class of people deriving their livelihood from agriculture included both landless peasants and large land-owners in addition to peasants working their own smallholdings. Following the reform, and neglecting the early abortive attempt to establish agricultural communes, agricultural production has taken place in private farms, estate farms and Peasant Self-Help Agencies (Samopomoc Chłopska) which have been referred to as "pseudo- co-operatives" (DiP, 1981: 225). In 1983, private

farms accounted for 76.2 per cent of arable land, with the remainder being managed by state farms (18.8 per cent) and co-operatives (3.8 per cent) (GUS figures). While 4,416,000 persons were economically active on just over 3 million private farms in 1977, 951,319 persons were employed in the socialised sector of agriculture (Rada d/s Rodziny, 1979a: 2).

Rural social policy often distinguishes between these different groups, but sometimes does not. Some policies refer to all persons resident in rural areas - for example, health care provision is organised on an urban-rural basis, some policy treats all those active in agriculture as a whole as a single group, while in other cases policy refers only to private farmers.

According to 1978 census data, women constituted 50.3 per cent of the rural population, and 57.2 per cent of the rural population aged 60 and over (Rocz. Stat. 1980: 35). Over a quarter of the women who work on private farms have been estimated to be over 60 (Rada d/s Rodziny, op. cit.: 24), and women as a whole form well over half (57 per cent) of the agricultural workforce in the private sector. However, in state agriculture women represented 26.5 per cent of employees in 1981 (Rocz. Stat. 1982: 57).

Figures based on data from successive censuses and shown in Table 2.22 below compares rates of economic activity inside and outside agriculture for men and women in different age groups in 1960 and 1970. Outside agriculture, although women's economic

activity has been rising dramatically, it still remains substantially lower than that of men. Women in agriculture have markedly higher rates of activity for all age groups, but differences are at their most extreme for women aged 45 or more. Between 45 and 59 years, non-agricultural rates slacken, while agricultural rates reach a peak. Very high economic activity rates for both men and women of "post-productive" age is a characteristic of agricultural workers.

TABLE 2.22: Economic activity coefficients by sex and economic sector (Poland; 1960-1978)

	Outside Agriculture			Inside Agriculture		
	1960	1970	1978	1960	1970	1978
MEN						
Total	54.0	56.0	55.3	57.8	62.0	63.8
18 years or less	2.0	0.9	0.8	5.2	5.0	2.7
18-44 years	93.0	90.0	89.1	95.1	92.2	91.1
45-65 years	87.4	86.6	78.1	98.7	99.0	99.0
65 years or over	24.8	21.9	7.9	87.6	91.3	86.4
WOMEN						
Total	27.9	37.9	40.9	58.3	63.4	58.7
18 years or less	1.3	0.8	0.6	6.3	4.9	1.7
18-44 years	52.8	69.6	72.7	87.5	85.8	77.8
45-59 years	40.8	59.0	58.2	89.7	94.4	93.9
60 years or over	9.6	8.7	3.8	68.4	78.9	71.1

Source: Rocz. Stat. 1980, Table 16, p. 41.

The ageing and feminisation of the work-force in the private farming sector is commonly identified as one of the main problems of Polish agriculture (Wyderko, 1973), and less typically as a

problem for women (Rada d/s Rodziny, op. cit.; Tryfan, 1977). An ultimate solution for both of these problems is commonly seen as the withdrawal of women from productive work in order to devote more time to their domestic role (e.g. Wyderko, op. cit.). However, at the moment this is not a practical possibility for most farms. The overall trend has been to the expansion of women's productive role in agriculture, this being in Tryfan's (op. cit.) view a result of male migration to employment in industry, coupled with a lack of a comprehensive pension scheme for private farmers.

Women are concentrated in small, labour-intensive farms. By the same token, the proportion of farms reported to be headed by women varies inversely with the size of the farm. This is illustrated by the figures in Table 2.23, which are based on Polish national census data for 1970.

The criterion used in this case to establish who runs the farm is whether the husband states that his main place of employment is outside the farm. When a family is asked who in its view carries out the function of head of family, as they were in a large scale survey carried out in 1972, the percentage of women regarded as "head of household" emerges as significantly lower (Wyderko, op. cit.). Thus while in 44.4 per cent of families paid employment had been taken up by heads of households, only 17 per cent of women were regarded by their families as performing the function of head of household. According to this second criterion, the percentage of farms run by women who are heads of household is also strongly negatively correlated

with size of farm, varying from 23.5 per cent on farms of 0.5 - 2 hectares to 7.8 per cent on farms 20 hectares and over.

TABLE 2.23: Size of farm by sex of person running the farm. (Poland, 1970).

Size of farm	Percentage run by women
0.5-2 hectares	62.2
2-3 "	53.9
3-5 "	39.8
5-7 "	27.2
7-10 "	19.7
10-15 "	13.2
15-20 "	10.0
20+ "	10.0
Total	38.4

Source: Wyderko, A. (1973), p. 51.

In a detailed study of eight farms, Bier (1967) has also found that women's input to farm work varies inversely with size of holding. She found the contribution of women to farm work (excluding the domestic household) varied from 20 to 45 per cent with an average of 24 per cent. Women were found, in accordance with the traditional division of labour, to contribute much to caring for livestock (44 per cent); children also played an important role in this activity, doing on average 24 per cent of the work involved. Women did on average 47 per cent of work around the farmyard and 27 per cent of work in the fields. A woman's working day was found to vary over the year from 11 to 16 hours (average = 12 hours), and was 2-3 hours longer than that of her husband. Men on average did 6 per cent of work

connected with the domestic household, while women did about 81 per cent.

However, in addition to this when necessary the woman takes over responsibility and management of the farm whereas the reverse, i.e. the man taking over such functions in the domestic household does not occur (Bier, 1967). When members of the family on small farms take jobs outside, before money can be put back into modernising the farm, the women is expected to keep things going on the same level as when everyone worked on the farm.

The responses to a questionnaire organised in 1971 by the magazine for peasant women "Gospodyni" showed that the farming jobs considered by respondents to be most burdensome were the spreading of artificial fertiliser by hand, mucking out and the spreading of animal manure on the fields, and the clearing of trenches between rows of potatoes or beet. As far as livestock was concerned, lack of water supply and proper equipment to look after the animals were the main problem (Dąbska, 1974). Much work must necessarily be done by hand for lack of simple tools:

> "indispensible, yet impossible to get hold of, is an ordinary cheap light barrow for taking feed to the animals which should be part of every farm's equipment. And so on most farms the woman still heaves buckets of feed by hand. She still, for example, chops up greens for the livestock using a knife or axe because there is no mechanical chopper for the purpose. The lack of this kind of handy implement is not compensated for, as some would have it, by mechanised household

> appliances which, it is true, are becoming increasingly abundant"
>
> (ibid.: 71).

Over 300,000 women belong to the Rural Women's Circle (Koło Gospodyń Wiejskich), and about 2 million to rural co-operative organisations. While these may provide some support, they are basically ineffective in the face of a massively underdeveloped rural infrastructure.

> "There is for example a huge need in the country for container gas and Rural Women's Circles have more than once put in collective orders which have not been met for years on end. And even if a stove has been installed, the delays of up to several months in exchanging containers mean that women cannot get the benefit of this godsend"
>
> (ibid.).

For all this, productivity on private farms is greater than on state farms as the Experience and Future (DiP) group has recently reported.

> "But especially unloved is individual peasant farming, which in all areas displays greater efficiency than state farms, co-operatives and farm equipment fleets. Given any parameters, even those in which large-scale farming can and should have a clear advantage - e.g., crop production - its productivity is lower than that of individual farms: grain yields per hectare of arable land on state farms are 20-25 per cent lower than on private farms, despite the fact that they are more highly mechanized and consume more chemical fertilisers, in other words, despite higher investments and costs. Statistics on livestock

> raising put the state farms in an even worse light. Hog production on state farms is six times more costly than on private farms"
>
> (DiP, 1981: 52).

Female labour is concentrated to a far greater extent than male labour in the smaller (and poorer) farms. Where there is a large female labour input to the farm, domestic roles necessarily contract as the following response to the 1972 "Gospodyni" questionnaire makes clear. The respondent was reacting to pervasive criticism of peasant women and their failure to provide balanced diets for their families.

> "Many women in the country know how to prepare culinary dishes to a high standard. But on the other hand, even with this knowledge, this kind of rational nutrition for the family sometimes has to go by the board ... what stands in the way most of all is a lack of time for cooking, particularly for cooking dinner. In our completely agricultural and highly productive region, women are out working in the field from spring to late autumn. At about midday the woman pops home and puts together something to eat as quickly as possible. There is no time then for any elaborate dishes, for example for vegetarian dishes, or for the preparation of salads or puddings, etc. "
>
> (woman farmer from the Łódź voivodeship)

Modernisation of farms need not entail an improvement in women's status; their domestic role grows as they retreat from productive work. Consider the following excerpt written by a woman sympathetic to peasant women's problems.

> "For example, on farms which have geared themselves to specialised production, not only have conditions arisen for mechanising

> the various processes in livestock-rearing, but a division of labour within the family is starting to be formed to the advantage of the woman, for it is usually the man who is responsible for the livestock rearing. The relieving of the woman of her work burden and the simultaneous growth of farm income means needs connected with the modernisation and fitting out with modern appliances of the household may be met; the kitchen, the woman's workplace, may be functionally equipped. It is therefore no accident then that the farm specialising in livestock production is often an example of a model rural domestic household, such as is the case, e.g. in the villages of the Bydgoszcz voivodeship"
>
> (ibid.: 72).

Conclusion

The relation of women to productive economic activity in Poland and Britain differs inasmuch as industrialisation has largely taken place in Poland only during the last half-century, and under state socialism with its command economy and ideological stress on economic independence as the basis of sexual equality. These historical differences have had important consequences for the meaning of women's work, female emancipation, the family and the state.

However, in many fundamental respects, the overall patterns in female employment in Britain and Poland are similar, despite Poland's higher global economic participation rates for women. This century has seen a dramatic increase in the proportion of women employed in the British and Polish economies, with childbirth presenting less of

an obstacle to continuity of employment in Poland than is the case in Britain. The influx has not taken place on an arbitrary, but on a highly selective basis with women in both cases tending to go into what has been traditionally viewed as women's work, namely textiles, nursing and teaching, or filling up newly-created occupations which have had a totally feminine work-force from the outset, such as the service industries. There has, however, been a greater move by Polish women into the professions and managerial positions. With few exceptions, the traditional view of the appropriateness of an occupation according to sex has had a similar outcome in each country. In spite of legislation prescribing sexual equality, the male/female dichotomy remains superordinate in determining the nature of the work a person does, and the rewards in terms of prestige, authority and earnings he or she may expect.

The percentage of the labour force in manufacturing industry constituted by women decreased in Poland in the sixties and seventies, but showed a slight increase in Britain over the same period. Apart from this, where it is possible to compare sectors of the economy, there is a degree of similarity in the extent to which women form part of the labour force, being over-represented in distributive trades and insurance and banking, and under-represented in construction and agriculture (i.e. the Polish socialised sector only). Polish women are additionally over-represented in state administration and the administration of justice.

Despite the absence of part-time working and the bi-modal work

profile among Polish women, and their higher overall rates of economic activity, rigid vertical segregation persists, even in highly feminised branches of the economy such as the textile industry, health and education, where women are concentrated at lower levels of hierarchies of authority and income. In areas which have been opened up to women through educational opportunities created by the post-war state socialist government, e.g. in academic teaching where women form a much greater part of the labour force than in Britain - approximately 35 per cent as opposed to 10 per cent in 1979/80 - stringent vertical segregation persists in a way that is not applicable in terms of educational lag. Women's entry as such into the socialised sector labour force has not contradicted traditional values; that they should be accorded positions of power and authority does.

Working wives contribute on average a greater proportion of the family income in Poland than in Britain. This is largely the effect of the tendency of British women to work shorter hours than their husbands. Average monthly or weekly earnings of full-time female employees are approximately two thirds of male earnings in both Poland and Britain. A dual labour market has been ascertained to exist in Poland as in Britain, with women being recruited into less well-paid jobs and forming an elastic labour reserve. Although women now constitute well over half of the labour force in private farming in Poland, there is a sense in which here too they are regarded as a labour reserve, only called upon when the needs arises.

Participation may have strengthened women's position within the private domain, but has not resulted in the taking over of ultimate authority in the running of farms.

Notes

1. Because of the complications of currency conversion, a precise and reliable comparison of Poland and Eng/Wales in this regard is unavailable. The Polish Statistical Yearbook 1982 quotes a GNP per inhabitant of 39,700 złoty and £3,540 for Poland and Britain respectively in 1980.

2. Illsley and Billewicz (1954: 155) concluded that the "type of mother is more important (in deciding whether a birth will be premature) than the conditions under which her pregancy is carried through", although a pilot study of theirs confirmed earlier findings that increased duration of employment in pregancy is associated with a greater likelihood a premature birth. More recently, the Short Report (HMSO, 1980: 20) has recommended in the interests of the reduction of perinatal mortality in Britain that the TUC should become involved in the welfare of pregnant women at work. At present the only statutory concession apart from maternity provisions enjoyed by such women is the entitlement to paid time for ante-natal check-ups (see p. 176). Until 1974 the Polish Labour Code banned night shift work for women between the fourth and sixth month of pregnancy, and required transferral to a more suitable work environment from the sixth month of pregnancy. In banning all night shift work for pregnant women and allowing for transferral to a more favorable work environment from ascertainment of pregnancy if a woman's health is deemed to require this, the 1974 Labour Code strengthened the hand of industrial health service doctors in a conflict situation where enterprise managers were pushing for higher productivity and often flouting Labour Code regulations (Butarewicz, 1982). With the new legislation and on the initiative of the now defunct Textile, Clothing and Leather Workers' Union protected work areas were created within factories for pregnant manual workers, as mentioned in Chapter I. In 1980, there were 46 such areas in Polish light industry. Comparisons of manual workers spending their pregnancy inside and outside these areas in the same factory have confirmed their role in raising

birth weight and reducing perinatal mortality (ibid.). For example, in Zdziennicki's (1978) study mentioned in Chapter I, perinatal mortality was reduced from 7 per cent to zero.

3. Computed on the basis of figures presented in Rocz. Stat. 1981, Table 20, p. 52.

4. In 1981, 21.1 per cent of employees in Great Britain worked part-time; 84 per cent of these workers were women (Empl. Gtte, December 1983). In the same year only 3.3 per cent of those employed in the socialised sector of the Polish economy were employed part-time at their main place of work. Just over half (54 per cent) were women (GUS, 1982: Table 1, pp. 10-11).

5. Of the country's 27.2 million inhabitants in 1921, 63.8 per cent earned their living from agriculture (Polonsky, 1980: 140).

6. According to Dyoniziak, Pomorski and Pucek (1978: 90), 43 per cent of the post-war increase in urban population up to 1974 was due to biological population growth, 33 per cent was a result of migration and 24 per cent the result of a re-drawing of administrative boundaries.

7. In 1937/38, women represented 31 per cent of new students in Poland and 33.8 per cent of enrolling full-time students in Britain. However, women received only 12 per cent of the higher degrees conferred in that year in Britain, the remainder receiving diplomas. In pure science, women represented 31.1 per cent of full-time students in Britain and 49.5 per cent in Poland; in agriculture they represented 17.6 per cent and 25.6 per cent respectively; in architecture, engineering, mining and chemistry 1.8 per cent and 7.4 per cent; in medicine and dentistry they represented a combined 16.7 per cent, and in Poland 21.9 per cent and 68 per cent respectively (Florecka, op. cit: 74, 145).

8. For a consideration of the principles underlying Polish family law, see Chapter IV.

9. An example of the official pressure towards discouraging the mothers of young children from employment is given by Fonda (1976: 46):

> "The Ministers are of the opinion that, under normal peacetime conditions, the right policy to pursue would be positively to discourage mothers with children under 2 from going out to work"
>
> (Ministry of Health Circular, 221/45).

10. Sullerot (1971) has also noted the absence of a two-phase work profile for women in East European societies.

11. The questions of maternity and paid and unpaid child care leave are dealt with in detail in Chapter V.

12. Although the trend has been to an increase in part-time working for women, it should be noted that between 1980 and 1981, the proportion of mothers with 3 or more children and working part-time fell from 36 per cent to 26 per cent according to the 1981 GHS. This may be associated with the fact that in 1981, 24 per cent of men in the same survey with 4 or more dependent children were unemployed, compared with an average of 8 per cent for all married men with dependent children. Although this probably represents an increase, no comparative figures are available for 1980.

13. This last factor is dealt with at greater length in the final section of Chapter V.

14. Markus (1975: 198) notes the fact that in Hungary female emancipation has also become a discredited value.

CHAPTER III

THE PUBLIC ECONOMY II: POVERTY AND INEQUALITY

Social Inequalities

If, in Britain, poverty is an integral part of an elaborate hierarchy of wealth and esteem (Townsend, 1979: 926), then in Poland it inheres in a system of what is primarily political exploitation. This fundamental difference has implications for the kind of resources to which the privileged have access, and for the nature of this access itself. For income from earnings and social security benefits, while forming the larger part of cash incomes for a great many people in both countries, is a partial and sometimes misleading indicator of the extent of social inequalities ignoring, for example, what may be substantial occupational welfare benefits (1). This has been underlined by such Polish writers as Jarosz (1981) and Tymowski (1977, 1980), both of whom point to the exclusion in the national figures of the extremes of the income scale, a fact which has been ignored in traditional Polish stratification studies (see, for example, Wesołowski (1970)). The GUS annual Family Budget studies, for example, exclude for reasons beyond its control a section of those living below the poverty line. Estimates of earnings differentials in Poland vary from 20:1 (Czyżanowska, quoted by Malanowski (1981) to 50:1 (The Helsinki Committee on Poland, quoted by Łoś (1980a)). By disaggregating members of the Party and security apparat from the raw Family Budget data for 1980, Jarosz has illustrated how one high earning group is normally submerged in the global figures for those employed in the socialised sector. The data

in Table 3.1 show that over 50 per cent of families in this group had a per capita monthly income of over 7,000 zł., whereas less than 5 per cent of other families in this sector reached a comparable income level.

TABLE 3.1: Estimated distribution of per capital income for selected population groups (Poland, 1980).

Family income in złoty per person per month	Total population	Population sub-groups					
		Those employed in the socialised sector			Private farmers	Pensioners	Maintained by State
		Total	Party officials, security police	Remainder			
	thousands						
Total	35,578	20.396	1,650	18.746	3.880	4.940	392
	per cent						
Total	100	100	100	100	100	100	100
up to 1500	5.75	1.87	-	2.03	8.62	12.20	100
1501-2000	9.02	6.03	0.04	6.56	10.57	18.53	-
2001-4000	49.87	50.40	6.21	53.90	43.80	55.97	-
4001-7000	27.79	33.25	40.17	32.63	27.36	12.53	-
7001-9000	4.44	5.17	24.76	3.84	5.53	0.64	-
9000+	3.13	3.28	28.82	1.04	4.12	0.13	-

Source: Jarosz, M. (1981), Table 1, p. 100.

In Britain, differences in earnings mask enormous inequalities in the distribution of wealth. Figures for 1981 show that while income from earnings for male employees varied between 169 per cent and 64 per cent of a median level of £123.50, 84 per cent of the marketable wealth in the country was in the hands of just 25 per cent of the

population (CSO, 1982, 1983). The importance of the inheritance of wealth in an economic system based on private property means in effect that it is the "exclusion from access to wealth, and especially from property (which) is perhaps the single most notable feature of the poor" in this country (Townsend, op. cit.: 921). What are the resources of the privileged in Poland, and by what means are they accumulated, given the lack of inheritance? Tymowski (1977) has indicated three such sources of affluence.

(a) Income linked to the particular attributes of a given job or profession

The position need not necessarily be an elevated one but is usually influential in some way. It may be that it offers the possibility of obtaining a car at a price which is much lower than its market value, and where the profit on resale would far exceed a year's salary. This "perk" is normally reserved for those occupying specific positions.

(b) Income derived from the distribution of the "social consumption fund"

This refers to differences in occupational welfare benefits or the "social wage". In addition to the welfare benefits widely distributed throughout society as a whole, there exist relatively small groups with rights to much more valuable benefits; they have at their disposal better-equipped hospitals and medical services, better holiday homes and obtain flats outside normal procedures. There are groups who have special privileges by reason of distinctions they have been awarded or because of length of service. "The breakdown of these privileges has been totally ignored by researchers", writes Tymowski, yet "an analysis of the problem is a sine qua non of obtaining an adequate picture of existing social stratification".

(c) Income derived from the secondary redistribution of private incomes

There are jobs and professions which although prima facie badly paid, nevertheless offer opportunities to increase earnings. These improved earnings are not registered, and involve payment for goods or services provided by persons in a private capacity to other such persons; it may also involve the payment of employees of state institutions for services directly rendered, or for arranging access to goods or better quality goods, etc. Whereas the sources of income described under (a) and (b) are strictly speaking legal, the practices referred to in this category may be semi-legal or illegal, and include such services rendered for payment as decorating carried out by decorators employed by state enterprises, home-helps, private childminding, private tuition, especially language tuition where rates of pay are much higher than in the socialised sector, together with the legal and illegal incomes from present-giving and bribery.

Malanowski (1981) has echoed much of what Tymowski earlier wrote (2), while Podgórecki (1976a) has pointed specifically to the way in which in a country with a degree of relative social homogeneity, the tendency to achieve "success" by exploiting the privileges associated with a given social position has replaced advantages which may be gained on the basis of wealth or ascribed social status. Yet another aspect of Polish life must be taken into account here. This is the network of informal contacts which form the channels for the exchange of goods, services and cash which obviate bureaucracy - a phenomenon which Podgórecki refers to as "squalid commonality":

> "external loyalties are cemented by means of family ties, the exchange of services,

> collaboration in the infringement of law, (...) participation in mutually advantageous informal arrangements and the possibility of mutual blackmail should it emerge that someone wishes to violate the code of this commonality - all of which creates a stronger bond than the impersonal demands made by rational administration. This network of mutual ties, by linking the various centres of "squalid commonality" in turn creates a kind of superstructure whose very existence has an effect on the social system"
>
> (Podgórecki, quoted in Kwaśniewski (1984: 19)).

It is against this background of political reward for the state elite and their political and security apparat, the oblique derivation of material advantage from particular positions within the occupational structure, and the web of covert practices facilitating the exchange of goods and services that the question of low wages, inadequate social security and welfare provision (with the exception of maternity benefits) and the lack of an officially maintained poverty line are to be viewed in Poland.

In terms of property, social inequalities do not stretch to encompass the vast concentrations of inherited wealth seen in Britain. However, when one considers indices which may be taken to bear a more direct relation to <u>biological survival</u>, then the degree of social variation is greater than in Britain. Part of the reason for this is the fact that in global terms Poland is a poorer country; another is the lack in Poland of a normative definition of poverty towards which wage and social policy might be oriented, given that the political economy as it now functions, generates both wealth and poverty.

Evidence to support thesis, comes in the first place for the infant mortality data presented in Chapter I. It will be recalled that figures were adduced showing that the post-neonatal mortality rate, i.e. deaths to infants aged between one and twelve months, which is the most sensitive indicator of environmental factors, in fact varied much more between social groups in Poland (as measured by level of education achieved by the mother) than in Britain (where the criterion of social status was the occupational class of the father). The infants of mothers with incomplete primary schooling are seven times more likely to die than those whose mothers have completed higher education, whereas in Britain, infants born to fathers in occupational class V, are three times more likely to die between the second to the twelfth month of life than their counterparts in occupational class I (see Table 1.8 and Figure 1.2).

There is further evidence that there are substantial social inequalities in Poland in levels of nutrition. Rafalski (1978) has compared inequalities in expenditure on food and nutritional intake in Poland and Britain on the basis of contemporary official data for each country (3). Overall, expenditure on foodstuffs in Poland represented on average 40 per cent of global household expenditure, whereas the corresponding figure for Britain is 25 per cent. Expenditure varied from 33 per cent in the most affluent group to 66 per cent in the worst-off group in Poland, and from 19 per cent to 36 per cent in Britain. Average daily calorie intake was marginally higher in Poland than in Britain, but varied by 1,943 calories in different income groups, while in Britain it did not vary by more than 800 calories; similarly with

protein, daily consumption of which varied by 62 gm in Poland and 33 gm in Britain, fats, which varied by 79 and 69 gm respectively and carbohydrates which varied by 217 gm and 93 gm.

Finally, recent information concerning inequalities in housing and sanitation in Poland comes from a nationwide Polish study based on a representative sample of 5,273 families (Jarosz and Bugaj, 1981). The study was specifically concerned with inequalities among families with dependent children. Among its findings which are of relevance to the Polish infant mortality data presented in Chapter I, was the fact that in families where the mother had the minimum level of education (incomplete primary schooling), over half (57.8 per cent) lived in accommodation which was not served by running water. Only 1.3 per cent of families where the mother had completed higher education lived in comparable conditions. The study presents a wealth of statistical data concerning housing inequalities according to a variety of factors such as income, size of town, educational level of the mother and occupational category of the "main breadwinner". An extract of data on housing according to occupational category is presented in Table 3.2. The data there on amenities may be contrasted with 1976 GHS data collected for Britain and shown in Table 3.3. While sole use of WC and bath or shower varies little by occupational class according to these figures, in Poland running water is lacking in 1.8 per cent of managerial households but in 31.8 per cent of the households of unskilled manual and non-manual workers, and in 52.8 per cent of peasant households.

TABLE 3.2: Housing Conditions and Income by Occupational Category (Poland, 1980).

	Management	Specialists	Administrative and Clerical	Industrial and Construction Workers	Service Workers	Unskilled Workers (manual + non-manual)	Self-employed	Private Farmers	Not Working
					%				
Type of Housing									
Owner-occupier	19.9	17.0	18.5	34.9	42.1	44.3	51.5	99.4	33.8
Private co-op	50.0	44.1	40.5	28.2	18.6	9.8	9.1	0.3	15.3
Local Authority	25.9	32.6	34.9	31.4	32.5	42.5	36.4	0.3	45.4
Sub-tenant	4.2	6.5	6.1	5.6	6.9	3.3	3.0	-	5.5
Facilities									
Electricity only	1.8	3.5	3.8	15.9	19.3	31.8	21.8	52.8	13.9
Elec. + running water	2.9	6.0	8.3	14.7	17.7	20.2	24.2	15.5	24.5
" " " + bath	14.1	12.3	19.6	17.0	15.7	17.7	15.2	11.6	24.5
Above 2 items + central heating	80.1	75.7	64.9	48.1	41.7	24.2	33.3	11.5	32.9
Density of Accommodation									
Fewer than 1 person/room	56.0	51.9	54.7	34.6	32.8	29.1	33.1	31.7	56.5
1.01-1.5 persons/room	29.8	32.1	28.4	34.5	31.6	32.1	36.4	30.6	24.1
1.51-2 persons/room	11.0	10.6	12.3	20.0	22.5	20.8	21.2	23.0	15.7
2 or more persons/room	3.1	5.2	4.5	11.0	13.1	18.1	9.1	14.8	3.8
Household Appliances*									
(1) Minimum	1.0	1.8	2.9	9.8	9.8	20.8	15.2	35.2	15.7
(2) Standard (a)	16.8	22.7	30.0	36.8	42.0	48.9	39.4	39.3	44.4
(3) Standard (b)	29.6	31.2	37.8	54.4	30.0	19.9	33.3	15.1	27.8
(4) High	49.8	39.9	25.2	16.4	14.7	6.4	9.1	5.8	9.8
Number of econ. active persons									
One	27.7	29.8	44.2	34.0	33.4	37.3	36.4	4.9	35.2
Two	67.0	65.1	45.6	55.0	50.2	45.9	39.4	48.3	16.7
Three	5.0	5.0	9.4	10.9	15.9	15.9	24.2	46.7	7.4
Per capita monthly income									
Less than 2,000 zl.	1.8	6.2	4.7	28.6	17.9	10.8	0.5	23.0	6.4
More than 4,000 zl.	17.4	22.4	5.2	24.0	8.1	2.1	0.1	17.7	3.1

*

(1) Minimum: up to 3 items from a basic category (a) including radio, black and white TV, electric washing machine, refrigerator, vacuum cleaner.

(2) Standard (a): 4-5 items from category (a).

(3) Standard (b): 4-5 items from category (a) and 2-3 items from a luxury category (b) including colour TV, automatic washing machine, car, tape-recorder, electric polisher.

(4) High: 4-5 items from category (b), regardless of number of items from category (a).

Source: Compiled from Jarosz, M. and Bugaj, M. (1981), Tables 5.3, 5.10, 4.10, 9 and 7.1.

TABLE 3.2: Housing Conditions and Income by Occupational Category (Poland, 1980).

	Management	Specialists	Administrative and Clerical	Industrial and Construction Workers	Service Workers	Unskilled Workers (manual + non-manual)	Self-employed	Private Farmers	Not Working
					%				
Type of Housing									
Owner-occupier	19.9	17.0	18.5	34.9	42.1	44.3	51.5	99.4	33.8
Private co-op	50.0	44.1	40.5	28.2	18.6	9.8	9.1	0.3	15.3
Local Authority	25.9	32.6	34.9	31.4	32.5	42.5	36.4	0.3	45.4
Sub-tenant	4.2	6.5	6.1	5.6	6.9	3.3	3.0	-	5.5
Facilities									
Electricity only	1.8	3.5	3.8	15.9	19.3	31.8	21.8	52.8	13.9
Elec. + running water	2.9	6.0	8.3	14.7	17.7	20.2	24.2	15.5	24.5
" " " + bath	14.1	12.3	19.6	17.0	15.7	17.7	15.2	11.6	24.5
Above 2 items + central heating	80.1	75.7	64.9	48.1	41.7	24.2	33.3	11.5	32.9
Density of Accommodation									
Fewer than 1 person/room	56.0	51.9	54.7	34.6	32.8	29.1	33.1	31.7	56.5
1.01-1.5 persons/room	29.8	32.1	28.4	34.5	31.6	32.1	36.4	30.6	24.1
1.51-2 persons/room	11.0	10.6	12.3	20.0	22.5	20.8	21.2	23.0	15.7
2 or more persons/room	3.1	5.2	4.5	11.0	13.1	18.1	9.1	14.8	3.8
Household Appliances*									
(1) Minimum	1.0	1.8	2.9	9.8	9.8	20.8	15.2	35.2	15.7
(2) Standard (a)	16.8	22.7	30.0	36.8	42.0	48.9	39.4	39.3	44.4
(3) Standard (b)	29.6	31.2	37.8	54.4	30.0	19.9	33.3	15.1	27.8
(4) High	49.8	39.9	25.2	16.4	14.7	6.4	9.1	5.8	9.8
Number of econ. active persons									
One	27.7	29.8	44.2	34.0	33.4	37.3	36.4	4.9	35.2
Two	67.0	65.1	45.6	55.0	50.2	45.9	39.4	48.3	16.7
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Per capita monthly income									
Less than 2,000 zl.	1.8	6.2	4.7	28.6	17.9	10.8	0.5	23.0	6.4
More than 4,000 zl.	17.4	22.4	5.2	24.0	8.1	2.1	0.1	17.7	3.1

*

(1) Minimum: up to 3 items from a basic category (a) including radio, black and white TV, electric washing machine, refrigerator, vacuum cleaner.

(2) Standard (a): 4-5 items from category (a).

(3) Standard (b): 4-5 items from category (a) and 2-3 items from a luxury category (b) including colour TV, automatic washing machine, car, tape-recorder, electric polisher.

(4) High: 4-5 items from category (b), regardless of number of items from category (a).

Source: Compiled from Jarosz, M. and Bugaj, M. (1981), Tables 5.3, 5.10, 4.10, 9 and 7.1.

TABLE 3.3: Facilities and type of housing according to occupational category (%) (Britain, 1976).

Occupational Class	Sole use of:		C.H.	Own/Occ.	Own/Occ. + Mortgage	Local Authority	Furnished rent priv.	Non-furnished rent priv.
	W.C.	Bath/Shower						
Professional	99	98	80	25	66	2	3	3
Employers, Managers	99	97	71	34	48	11	5	2
Intermediate non-manual	96	94	59	28	44	15	8	5
Junior non-manual	96	92	50	30	26	29	11	4
Skilled manual + own account non-professionals	98	94	44	19	29	42	8	1
Semi-skilled manual + personal service	95	88	33	18	15	53	12	2
Unskilled manual	97	87	29	16	5	65	12	2

Source: General Household Survey 1976, Tables 2.28, 2.29.

Again, with respect to density of accommodation, 44 per cent of Polish managerial households had fewer than one room per person while 70.9 per cent of the households of unskilled workers lived in the same conditions. Contrasting this with Townsend's 1967-9 figures where none of his professional and managerial class and 9 per cent of his partly and unskilled households had less than one room per person (Townsend, op. cit.: 482), we can see the much greater overall degree of overcrowding in Poland together with its more significant variation with occupational category. In fact the figures would have been even more dramatic contrast were it not for the fact that families living with parents or parents-in-law were specifically ommitted in the Polish study while the procedure for collecting statistical information on housing counted kitchens which met certain requirements as separate rooms.

In passing it is interesting to note that local authority low rent housing is much more evenly spread over the occupational categories than is the case in Britain, while occupation is fairly closely related to whether or not a family lives in housing obtained through the semi-private co-op scheme, either on an ownership or subtenanting basis.

Normative Poverty

The concept of subsistence is one with an established tradition in Britain, both in poverty studies and social policy. Its antecedents are to be found in the Poor Law, with its concern to provide an ultimate defence against destitution, while the first study designed to establish a "poverty line" dates back to the famous work of Seebohm Rowntree in York during the nineteenth century. The "poverty line" he wished to determine was a level of income sufficient "to obtain the minimum necessaries for the maintenance of purely physical efficiency" (Rowntree, quoted in Townsend, op. cit: 33). Further generations of such studies influenced the proposals made by Beveridge in his 1942 report. However, the advent of the welfare state did not mean the elimination of poverty in Britain, as the poverty studies of the sixties revealed.

Increasingly, the importance of the social component in a social minimum has come to be recognised and its essential relativity understood by policy makers:

> "... it is not sufficient to assess poverty by absolute standards; nowadays it must be judged by relative criteria by comparison with the standards of living of other groups in the community ... beneficiaries must have an income which enables them to participate in the life of the community"
>
> (DHSS Parliamentary Under-Secretary, House of Commons, 6th November 1979, quoted in CPAG (1983:2)).

In contrast to this, the Polish authorities have been persistent in their refusal to give any form of conventional acknowledgement of the existence and extent of poverty - until 1981, that is, when an official poverty line was officially adopted on demand from Solidarity as a base on which to peg pension and child allowance rates. However, much of the groundwork for this new policy had been laid down by social scientists who from the sixties had been attempting to formulate a basic subsistence level, but whose work had either not been published, or if published had failed to influence policy or policy-makers. Foremost among such workers was Andrzej Tymowski (see Chapter I, note 10).

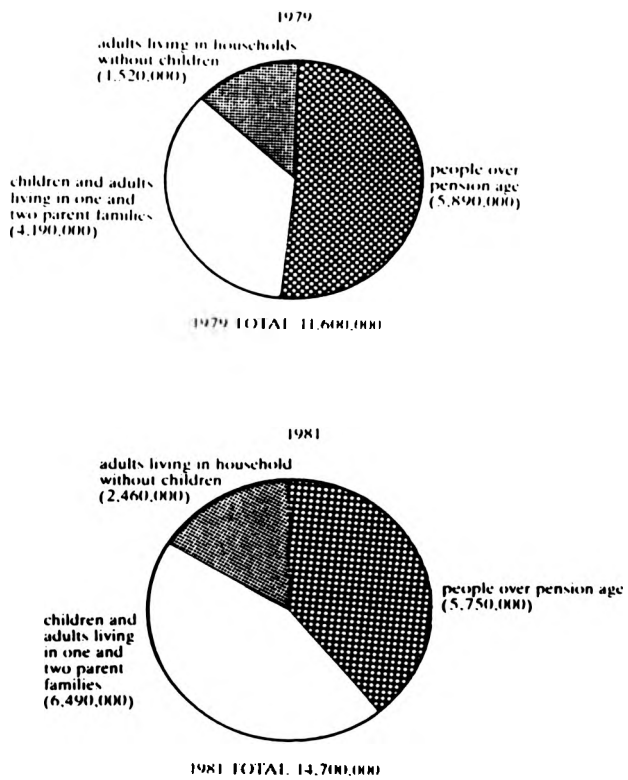
Similar models were at the same time being developed by Deniszczuk, who in 1966 and 1968 presented the results of her work to the Central Trades Unions Committee (Deniszczuk, 1981a). Throughout the seventies she was responsible for furnishing reports on research concerned to establish a social minimum to the Central Planning Commission who then used the results for the purposes of their own internal studies, but did not use them to form the explicit basis of a policy to deal with poverty. Such work, however, may have influenced the implicit poverty

line defining eligibility for such means-tested benefits as the higher rate of child allowances, free school meals and allowances from the State Alimony Fund.

Supplementary Benefit rates have been consensually adopted in Britain as a de facto poverty line. This definition is commonly officially extended to include persons living "on the margins of poverty", i.e. those with an income of up to 140 per cent of current Supplementary Benefit rates, as for example by the DHSS in its Low Income Tables (DHSS, 1983). Even this level, however, is regarded as inadequate by some researchers (e.g. Piachaud, 1981). Nevertheless, if one adopts this normative definition of poverty, certain clear trends are discernible. In the first place, poverty in Britain is increasing; in 1979 there were just over 11½ million poor while just two years later this figure had risen to approximately 15 million. Secondly, it is now parents and children, rather than the elderly, who predominate among the poor (see Figure 3.1).

In large part, this has been the consequence of the rapid increase in unemployment since 1979. Between 1979 and 1981, the number of persons living in unemployed households trebled (CPAG, 1983; DHSS, 1983). For those in employment, pay differentials have also widened dramatically since 1979 (Metcalf and Nickell, 1985). Since that year, men's pay in the lowest decile and quartile has worsened relative to the median value, while pay in the upper quartile, and particularly the upper decile, has improved. In consequence, the number of persons living in or on the margins of poverty in working families rose by over

FIGURE 3.1: People in Poverty (Britain, 1979 & 1981).



Source: Graham, H. (1984), Figure 0.1, p. 3.

50 per cent in the period between 1979 and 1981 (DHSS, op. cit.). Data for 1981 (shown in Table 3.4) indicate that those dependent on full-time work or self-employment still constitute the numerically largest group among those above pension age who are living in or on the margins of poverty.

TABLE 3.4: People in or on the margins of poverty by employment status (Britain, 1981). (thous.)

TABLE 3.4: People in or on the margins of poverty by employment status (Britain, 1981). (thous.)

Employment Status	Income Level				
	Below SB	SB	Over SB* - 40% above SB	Total up to 40% above SB	Total no. of people in G.B.
Under Pension Age:					
Full-time work or self-employed	680	-	3160	3840	35790
Unemployed over 3 months	480	1620	510	2610	3470
Sick or disabled over 3 months	100	230	430	760	1600
Other	440	1040	440	1920	3690
Over Pension Age:	1120	1960	2810	5890	8820
Total				15020	53370

* Age related heating addition included as part of SB scale

Source: Compiled from: DHSS (1983), Tables 1, 2, 5 & 7.

Thus low pay, a low tax threshold, inadequate child benefit and the failure of means-tested benefits are significant immediate causes of poverty in Britain in addition for unemployment, sickness and old age. Moreover, were it not for the earnings of women it has been estimated that the number of working families with incomes below the Supplementary Benefit level would be increased fourfold (CPAG, op. cit.: 6). Inadequate maternity and child day care provisions must in the light of this be a cause of poverty in a significant number of families at a particularly vulnerable stage of the life cycle. These are all factors which are felt particularly keenly by one-parent families. The numbers of such families is rapidly increasing - between 1976 and 1981 numbers increased by 30 per cent - and moreover, half of these families are poor (Graham, 1984).

The poverty line adopted in Poland in 1981 was 2,500 zł per person per month, and in 1980 stood unofficially at 2,000 zł. According to this criterion and on the basis of Jarosz's re-analysis of 1980 income figures, 8.59 per cent of those employed in the socialised sector are in poverty, and they too comprise the numerically greatest group of the poor (Table 4.1). According to these figures also almost 20 per cent of peasant families are in poverty. The official espousal of the concept of a national minimum in 1981 was associated with an intention to relate pensions and child allowances to subsistence requirements, and it is true to say that child allowance rates were revised significantly upwards in the same year. However, as has been noted, since that time spiralling prices have left the official poverty line operationally invalid as a means of regulating these benefits. Moreover, the adoption of a national minimum did not entail any form of guarantee that all incomes would be brought up to this level, and there is in fact very little information concerning the actual depths that poverty may plumb in Poland. Some indication of this is, however, provided by Jarosz's (1980) study of fatherless families. Carried out between the years 1973 and 1975 and involving a random 25 per cent sample of all one-parent families where the father had been convicted during 1973 for failure to maintain, the study revealed that in many cases per capita monthly income was below 500 zł, i.e. less than half the poverty line of 1,000 zł postulated by Tymowski (1976) for 1970, one third of the estimated poverty line for 1975 of 1,500 zł, and "less than the biological minimum" (Jarosz, op. cit.). Jarosz has estimated that approximately 96,000 children under the age of 17 live

in this extreme poverty. As one might expect, the families were found to suffer the cumulative effect of deprivation in all aspects of social life: the level of education of the mother and her occupational status were very low, housing conditions were cramped (with an average of 2.19 persons per room against a national average of 1.29) and health was poor. Despite this, in only one third of cases did any form of state assistance reach the families, this for the most part taking the form of occupational welfare benefits (ibid.). For Poland as a whole, unpublished GUS data show that in 1980, a relatively small number of children living with their natural families (144,927) received some form of social assistance, but only 57,056 of these were in receipt of regular benefit (see Table 3.5).

TABLE 3.5: Children in natural families in receipt of public assistance cash benefits (Poland, 1980).

Number of children	Number of families	Regular benefit	Once-only benefit
144,927	90,463	57,056	87,871

Source: Extracted from GUS (1981), Table II, p. 92.

If anything confirms the soundness of the thesis that poverty is in essence an evaluative and relative phenomenon, it is the similarity of estimates of the extent of poverty among children in the two countries. This is particularly clear in the case of two recent studies, one in Britain and one in Poland, both of which attempt to define the extent of poverty among children in these countries.

By costing the normative minimum requirements for children at 2, 5, 8, and 11 years, together with the minimum needs of teenagers as expressed by teenagers themselves, Piachaud (1981) has estimated that 5.4 million out of a total of 13.6 million, i.e. 40 per cent of all children under 16 were living in families with an income of less than 140 per cent of his adjusted Supplementary Benefit level in 1981 (4). Using a similar approach but different methodology, Deniszczuk (1981b) has estimated the minimum maintenance costs of twelve different family formations, as is shown in Table 3.6.

TABLE 3.6: Average cost of upkeep per person on the poverty line (Poland, 2nd quarter 1980).

Households with:	Cost per person per month (zł)	Households with one child aged:	Cost per person per month (zł)
Two children aged:			
0-1 and 2-3 years	1932	0-1 years	2078
4-6 and 7-12 years	1977	2-3 years	2020
13-17 and 18-24 years	2386	4-6 years	2020
Three children aged:			
0-1, 2-3 & 7-12 years	1949	7-12 years	2150
Four children aged:			
2-3, 7-12 13-17 and 18-24 years	2168	13-17 years	2280
Five children aged:			
2-3, 4-6, 7-12, 13-17 and 18-24 years	2068	18-24 years	2452

Source: Deniszczuk, L. (1981b), Table I, p. 11.

By comparing these normative requirements with the poverty line she also concluded that 40 per cent of dependent children and young people under the age of 24 years were living in poverty in Poland in 1980. The fact that the Polish and British studies have ascertained a similar proportion of children in to be living in poverty in these respective countries, does not of course mean that the experience of what is called poverty is itself comparable in each case. The lack of a social minimum in Poland, coupled with Jarosz's (1980) findings with respect to one group of the very poor to which we have referred above, precludes this.

Notes

1. For an analysis of the Polish occupational welfare system, see Chapter V.

2. "in addition to land and housing, all other goods which were hard to come by were subject to group privilege. They include, first and foremost, the allocation of cars at below market prices, the use of special health services and establishments equipped with unique apparatus and imported drugs, the possibility of educating one' children abroad, access to the Ministerial pool of university places, the facility to arrange flats for one's children by 'jumping the queue', exemption of sons from military service (and) access to special foodstuff supplies" (Malanowski, op. cit.: 144-5).

3. For Britain: Household Food Consumption and Expenditure 1976, HMSO 1976.

   For Poland: Spożycie artykułów żywnościowych w gospodarstwach domowych w 1974 r. (Household Food Consumption 1974), GUS 1976; Rocznik Statystyczny 1977.

4. The DHSS, however, estimate that 34 per cent of children are living in families with an income below 140 per cent of Supplementary Benefit (Graham, 1984: 25).

CHAPTER IV

THE DOMESTIC ECONOMY

A Quantitative Comparison

In statistical terms, the family formation which consists of one or two parents and their children is significantly more prevalent in Poland than it is in Britain. Parents and children who live together in the same household accounted for 76 per cent of the Polish population in 1978, but just under one half of the British population in 1981 (Rada d/s Rodziny, 1981; DHSS, 1983). More detailed Polish census data for 1978 is reproduced in Table 4.1.

TABLE 4.1: Total number of family members and families by family type (thous.); percentage of families by number of children and family type (Poland, 1978).

	All	Married Couple with/without children	Mother & Children	Father & Children	Siblings
Total families	9,434.7	8,093.6	1,109.7	139.5	91.9
Total persons	31,087.2	27,797.3	2,747.6	343.7	198.6
Older generation	17,436.4	16,187.2	1,109.7	139.5	-
Children (all)	13,650.8	11,610.1	1,637.9	204.2	198.6
Children (under 24 years)	10,369.5	9,311.8	925.8	92.9	39.0
Families with no children under 24 years (%)	38.8	37.7	42.1	52.5	76.4
Families with no children (any age) (%)	22.2	25.8	-	-	-
Families with 3 or more children (any age) (%)	14.9	15.8	9.8	9.6	12.8

Source: Compiled from national census data reproduced in Rada d/s Rodziny (1981), Tables 2.5 and 2.9, pp. 11 and 15.

These show that single parents with children constituted 17 per cent of all families with children in that year. However, if one takes into

account only dependent children under 24 years of age, this figure falls to 12 per cent. In Britain single persons with children represented 13 per cent of all under pension age families with children in 1981 (see Table 4.2).

TABLE 4.2: Total number of families and persons by family type (thous.) (Britain, 1981).

	Families	Persons
All Families	27,020	53,360
Total families over pension age	6,470	8,820
(a) Married couples	2,310	4,650
(b) Single persons	4,160	4,170
Total families under pension age by family type	20,560	44,540
(a) Married couples with children	6,150	23,730
(b) Single persons with children	940	2,570
(c) Married couples without children	4,770	9,540
(d) Single persons without children	8,700	8,700
(e) Of which large families (3 or more children)	1,280	6,650

Source: Extracted from DHSS (1983), Table 6.

In both Poland and Britain, just under 90 per cent of one-parent families (89 and 88 per cent respectively) are headed by women. On average, however, single parents in Poland have to care for rather fewer children than is the case in Britain (1.4 children aged under 24 as opposed to 1.7 children in under pension age families; figures derived from Tables 4.1 and 4.2). In some measure this is explained by differences in divorce patterns (see Table 5.3 and Figure 5.1).

The Normative Framework

As in the Soviet Union, the family in Poland has been the object of explicit public policy. Official views concerning the nature of the family are expressed most clearly in the Family Codes which have been formulated during the post-war period. However, unlike the Soviet Union, these did not embody an early attempt to undermine the legal and social bases of marriage and the family. In fact, the Family Code which Poland adopted in 1950 was a version of the 1944 Soviet Family Code which had been concerned to re-establish the stability of the family (1). On the one hand, the new Family Law set out to codify the equality of spouses within the family - an equality which was predicated on the economic activity of women outside marriage, for although marital maintenance existed it was a reciprocal notion and not one derived from a notion of marriage as a way of earning one's livelihood. The traditional division of authority and responsibility was replaced by collective headship where "both spouses have equal rights and duties" (FC art. 23), and "decide jointly on important matters affecting the family" (FC art. 24). The second general principle underlying Polish family law is the unity of the family, and is at its clearest in matters concerning matrimonial property. Together these two fundamental principles, sexual equality and the unity of the family, express what Lapidus (1978: 235) has called "the contradictory imperatives of female liberation and family cohesion". What made these imperatives contradictory was the failure at any point to give serious consideration to the interdependence of male and female roles. Furthermore, inasfar as the unity of the family on these

terms was paramount to the interests of the state, the principle of sexual equality was subordinated to this unity.

> "The law purports to give preference to that principle which under all circumstances appears more rigorously to support the socialist concept of marriage and its role in society"
>
> (Lasok, 1968: 73).

It is in sexual equality that Polish writers and ideologues have seen the legitimate claim to the superiority of socialist marriage over capitalist marriage, yet the same concept allows for the subordination of the principle of sexual equality to state interests, should the need arise. This is the central contradiction which lies at the heart of the ideological construction of the family in Polish family law.

The interests of the state are bound up with production and reproduction rather than with marriage itself, and it is in these areas that the tensions between sexual equality on the one hand, and state interests on the other, become more apparent. Thus while the mass induction of women into the labour market was to be the economic basis for equality within marriage, the interests of the modernising state were articulated in the preservation of patriarchal values in the public domain - and in the family. Legal instructions issued in January 1953 by the Minister of Health in connection with the drive to increase female employment nicely illustrate this point (2). The instructions exclude able-bodied men below 45 years of age from a range of jobs within the health service and allied industries. For the most part, these are low-status service jobs generally requiring

little skill; in substance many represent the recognisable public equivalent of traditionally feminine tasks within the public domain, e.g. laundry workers, kitchen workers (except for master chefs), dieticians, cloakroom attendants, cleaners, shorthand typists, secretaries, etc.

Although one would not wish to underplay the importance of the shift of women into paid work, it is nevertheless true that on the terms under which this shift took place, the "liberation" of women also in a sense represented their further confinement. This found ideological expression in the notion of women's "dual role", as employees and as workers and carers within the home. A lack of commitment on the part of the state to collective services, particularly the crèche and day nursery system, increasing demographic concerns and the new ideological stress on the family in the seventies - all served to crystallise on a grand scale the fundamental ambiguity of Polish family law. Another potent barrier to the undermining of the traditional allocation of roles within the family in Poland is the heightened importance of the family unit as an economic and psychological resource in a context where the state suffers from a crisis of legitimacy, where the primary relations of the family constitute the main nuclei of a counter-culture vis-à-vis a devalued public domain, and particularly where this counter-culture is instrumentally associated with the Catholic Church, and Catholic traditions. In Britain, where the family is primarily construed as a "private" area of social life, there is no identifiable body of laws comparable to a Family Code to deal explicitly with relations within the family unit. However, as

the writings of Land (1976; 1978) have amply demonstrated, a very wide range of social policies depend on the acceptance of the assumption of a male breadwinning and providing role, with women the primary workers and carers within the home. The very "naturalness" of such assumptions reflect their power. Modern tax and supplementary benefit law still depend on such assumptions and as a result deprive many married women of their full civil rights. The same is true of the administration of the Invalid Care Allowance which is available to men and single women who give up employment for an elderly and severely handicapped relative. Being deemed to be the dependants of their husbands, married women, and under some circumstances widowed or divorced women, are ineligible for this allowance, although as evidence cited by the EOC (1982b) has shown, such carers are overwhelmingly women, and most women are married.

Nissel and Bonnerjea (1983) have estimated the substantial individual opportunity costs of these arrangements, while public savings of £40 million per annum are claimed as a result of excluding married women from the invalid care scheme (Rimmer, 1983) (3). It is for this reason that the community care policies which have received recent political and ideological emphasis in Britain have been described by the EOC (op. cit.: 3) as "a euphemism for an under-resourced system which places heavy burdens on <u>individual</u> members of the community, most of them women. It represents care 'on the cheap'."

The Sociology of the Family in Poland

The course Polish sociology has taken has been intimately bound up with political changes in that country. The origins of Polish sociological work on the family go back to such writers as Ludwik Krzywicki (1859-1941), Florian Znaniecki (1882-1958) and Bronisław Malinowski (1884-1942). Although sociology of the family did not exist in the inter-war years, writers continued to deal with family life in departments of rural sociology and ethnography, e.g. J. Chałasinski who in 1938 published "The New Generation of Peasants" using personal documents which indicated the conflicts in the life of the traditional peasant family. The year 1956 saw a revival of Polish sociology after a dormant post-war period, and research into the family was initially conducted as part of rural or urban sociology (the latter being especially concerned with the problem of working mothers). Only towards the end of the sixties did "the family" emerge in its own right. In the mid-sixties the Warsaw Centre for Research into the Contemporary Family was opened, and in 1970 the Sociology of the Family section of the Polish Sociological Association came into being (Tyszka 1976).

Sociology as a discipline has grown rapidly in Poland since the war. We learn from Szczepański (1980), for example, that whereas in 1945 there were only 8 professors and doctors of sociology in Poland, in 1978 there were 100 such professors. If there was expansion, there were also qualitative changes. Early on, traditional chairs were replaced by Institutes (involving an institutionalised shift of power

away from the academic to the administrative, and hence political). The most substantial changes came at the beginning of the seventies when large-scale governmental research programmes and "key topics" were established. According to Szczepański, these were large projects in which several institutions were called upon to cooperate, and where new forms of planning, coordination, financing and control were needed.

Polish sociology has been seen as being essentially "pragmatic", and especially so after the political changes of 1970 (Sokołowska, 1974; Szczepański, op. cit.). The new political leaders saw the ideological purposes the social sciences might serve and also showed a willingness to use them as the rational foundations for social policy and social planning which it has been pointed out entered into the official vocabulary for the first time in December 1970 (Sokołowska, op. cit.; Markowska and Dodziuk-Lytyńska, 1975). Insofar as such social policy was built upon an unchallenged traditional division of labour within the home, was concerned to ease the tensions between women's childrearing responsibilities within such a division of labour and their productive role in employment, and was relatively unconcerned with problems of poverty and social inequality, this is true. In this context, the "pragmatic" sociology of the family was an overtly functionalist one, lacking in critical or truly feminist perspective.

Sexual Egalitarianism and Modernisation

Over 400 major studies of the family have been carried out since

the war in Poland. Many of these studies have been used by Markowska and Dodziuk-Lytyńska (op. cit.) as the basis on which they have constructed a typology of families in Poland. The value of their approach, which is based on a theoretical model of phases of modernisation developed in 1963 by R. Turski in relation to rural communities, is that it highlights the heterogeneity of the family in Poland. Its weakness lies in the teleological nature of the argument which creates theoretical movement along a continuum marked at one extreme by the traditional patriarchal family and at the other by the modern egalitarian family. The authors distinguish eleven family types as follows:

Agricultural families

1) Traditional farming families.
2) Farming families where farms/household are in an initial stage of modernisation.
3) Farming families where farms/household are in an advanced stage of modernisation.
4) Families with modernised farms/households.

Mixed income families

5) Traditional farmer-worker families.
6) Farmer-worker families in process of modernising.
7) Worker-farmer families in process of modernising.

Worker families

8) Traditional worker families.
9) Worker families in initial stage of modernisation of household.
10) Worker families in advanced stage of modernisation of household.
11) Modernised worker families.

1. Traditional farming families

This type comprises the approximate 10-15 per cent of smallholding families who live by subsistence farming. The household is headed by the man and there is a strict sexual division of labour. The authors say that certain elements of patriarchy are now only convention rather than the real domination of the husband.

2. Farming families in an initial stage of modernisation

This type accounts for 50 per cent of smallholding families. Here, the family practises subsistence farming with certain innovations, such as non-capital intensive investment for a quick return, without this leading to further modernisation. Important decisions are taken by all the adults together; the traditional division of labour persists, although the division of labour in new tasks has not crystallised. Home processing of food is regarded as a cheap way of feeding the family, involving female labour which is not costed. Contact with the outside (e.g. agricultural services, the market) is the male task.

3. Farming families in an advanced stage of modernisation

This type accounts for just less than 30 per cent of smallholding families. Unavailable goods and services means that subsistence persists, although 75 per cent of produce is for exchange. The official head of the family is still the man, although important decisions are taken collectively. There is a revision of the traditional division of labour here, but the man still represents the household on the outside and the woman takes care of the domestic tasks. The new appliances which are introduced do not shorten the woman's work time.

4. Modernised farming families

Only 3-4 per cent of private farming families may be classed in this category according to the authors. Here we see specialised agricultural production with a strong market orientation, although again shortages of food and food outlets in rural areas force a certain amount of production for consumption. Often the man and son or daughter run the holding while the wife concerns herself with domestic tasks, although married couples do sometimes run this kind of holding together. According to the authors there is a strict division of labour but not according to traditional criteria, more according to the needs of the holding and individual suitability - thus the wife or daughter may represent the holding on the outside.

5. Traditional farmer-worker families

These families represent a marginal type, and are of low status, both in agriculture and outside it. The representative is the male, regardless of the amount of work put in by the woman and although she may be responsible for the day-to-day running of things. There is a lot of domestic processing of food, not more than 25 per cent of produce being sold.

6. Modernising farmer-worker families

In these families, representing about 30 per cent of mixed income families, income from agriculture is greater than waged income. The husband often has higher educational qualifications than his wife, and he represents the holding on the outside. Decisions are collective.

7. Modernising worker-farmer families

Where both husband and wife are employed, their parents often help out. This three-generational family differs from the traditional three-generational family in that the woman is often also the recognised head of the holding. Male decision areas disappear, certain spheres remain within the competence of the woman. The fact that women represent the holding is not only caused by the fact of the husband's working, but also by the fact that the holding is no longer a way of meeting prestige needs. There is a gross divergence here between women's work and their position in the family. The husband gets trained and has wider social contacts. Aspirations as to the future occupations of children are defined by the father's experience, although the mother carries out the day-to-day rearing. This type accounts for 60 per cent of mixed-income families.

8. Traditional worker families

These are the families of skilled and unskilled manual workers and unskilled non-manual workers and represent about 25 per cent of worker families. They tend to live in small towns and over one third have only one breadwinner - the husband. Thirty per cent of these families live in three-generational households and there is a distinct traditional division of labour, regardless of whether or not the woman works. They do want education for both sons and daughters, though this is not always followed through in practice. The children usually spend their summer holidays with relatives in the country or at home.

9. Worker families in an initial stage of modernisation

About 30-40 per cent of all worker families. In about one quarter the male is the sole breadwinner. Most want the same level of education for sons and daughters but in different sex-stereotyped fields. There is a lack of egalitarian relations, especially in three-generation households. Children go to summer camps during their holidays.

10. Worker families in an advanced stage of modernisation

These families, over 30 per cent of worker families, usually have two wage earners, though not on the same socio-occupational level. Even if the wife has superior qualifications, she usually earns less. The husband often takes extra commissioned work. Again, the children usually go to a camp during the summer.

11. Modernised worker families

These are intelligentsia families - about 6 per cent of all worker families. At least one spouse is a graduate. About one third have a paid home-help. The children usually go on holiday with their parents.

There are assumptions involved here which are open to question if one looks at the typology as part of a theory of change linking tradition and patriarchy on the one hand and modernisation and egalitarianism on the other. Modernisation and egalitarianism are both complex concepts and are not related to each other in any simple way. Gail Lapidus (1974) has analysed these concepts with reference to studies of social change in the USSR which have also been centred on an antithesis between tradition and modernity. She points out that

overemphasis on change in sub-systems as a consequence of changes in economic organisation has led to too little emphasis on the influence on change of cultural norms, political institutions and processes and ideological commitments. She distinguishes four approaches to the relationship of modernity to sex roles, i.e.

(a) the Parsonian approach, whereby modernisation entails an increasing differentiation of sex roles;

(b) the androgynous approach where there is a movement away from sexual polarisation and distinctively male and female attributes merge into essentially human ones;

(c) the assimilationist approach where modernisation is seen as a process of democratisation in which economic, legal and political equality is gradually extended to ever wider circles of man and womankind; it is a unilateral strategy.

(d) the pluralist approach which envisions a society where men and women choose from a variety of options in the absence of social constraints or sanctions.

The goals of pluralism or androgyny were never accepted by the Soviet leadership as their own - Beatrice Farnsworth's (1978) account of their hostile reaction to A. Kollontai who favoured an androgynous approach, shows this clearly. But if the goal was assimilation, this cannot be a simple function of economic development for women have taken over male roles in a highly patterned and predictable way, both with regard to the occupations they have gone into, as Safilios-Rothschild (1971) has shown, and with regard to levels reached within occupations.

The assumption that peasant and worker families may be aligned along the same theoretical continuum is one which is open to certain qualifications. The peculiar nature of agriculture as a way of earning a living, the differing demographic characteristics of peasant families, the policies the state has adopted towards private farmers as a group - all these factors contribute to the fact that productive and reproductive roles are articulated rather differently in such families. Many of the extensions of benefits to worker families in the seventies which are described in Chapter V simply do not apply to private farmers. Day nurseries have not been an option for women on private, as opposed to state farms: according to the 1978 GUS survey of the day care of pre-school children 99.5 per cent of children under 3 in peasant families and 100 per cent in mixed-income families are being cared for at home (Wojciechowska, 1979). The number of seasonal day nurseries caring for children during harvest-time, has also fallen dramatically (see Table 5.12). The situation with nursery schools is rather better. 26.3 per cent of children aged 3-6 in peasant families, and 21.5 per cent of children in mixed-income families attend, this being rather lower than the average of 42.4 per cent obtained for the national sample (ibid.). A pre-school year for 6 year olds is now almost universal.

The modernisation of farms has in general brought two-way changes to the traditional division of labour in farming, with women now also working in the fields and men also involved in livestock rearing (Tryfan, 1977). Moreover, in mixed-income families much, and sometimes all, of what was formerly the man's work is done by the

woman. While the introduction of modern machinery has lessened men's work, women are often involved in intensified livestock production and the introduction of new domestic crops. Modernisation may often therefore bring women an expanded productive role rather than a reduced domestic role. The latter in this situation may be subjected to economies of time and effort, for example, several children or children and grand-parents may share a bed. As a respondent in one study said, "(i)f everyone slept separately, I'd be here till mid-day making the beds" (Rybicka, 1970). It is this situation which has prompted one author to state

> "the rise in income and standard of living in rural areas has been achieved at the cost of a vastly overloaded timetable, by enormous physical and mental effort and a huge work-load on every member of the family, especially the woman"
>
> (Ignar, 1980).

In some families, however, modernisation of the farm may mean a withdrawal of women from productive work, and an expansion of her traditional domestic role, as Markowska and Dodsiuk-Lytyńska recognise, and as has already been mentioned in Chapter II.

The complex nature of the relationship between modernisation and the egalitarianism of family relations is reflected in the effect which the paid work of women has had on attitudes which have been expressed in sociological studies. For example, using two samples of married men, one from Łódż and one from Warsaw, Kłoskowska (1962) found that on the whole the Łódż workers expressed more egalitarian attitudes although they were less qualified, had a lower standard of living and more were of peasant origin. The author concluded that

the responses had been affected by the fact that Łódź was a town with a tradition of paid employment for women, and where women made a vital contribution to the family budget. Piotrowski (1962) on the other hand, found that only 2 out of 172 Silesian miners in 2 mining communities with a female employment rate of 7 per cent, thought that married women without children should work.

In general the effect of Poland's historical experience, i.e. the mass employment of women, seems clear. Sokołowska (1976a) notes that sociological research has shown that traditional attitudes are associated with increasing age and a lower level of education. Amongst such research is Piotrowski and Mogey's (1978) complex correlational study, while Tyszka (1980) in summarising research carried out at the Adam Mickiewicz University in Poznań, has shown that women with higher education are unique in the frequency with which they perceive inequality within the home. The consistency of these attitudes and how they relate to actual practice is, however, another matter. Kłoskowska (op. cit.), for example, found that the attitudes of male respondents were more ambivalent when they referred not to women en masse but to their own domestic situation, where there was a more noticeable tendency to preserve the traditional distinction between the roles of husband and wife - a symptom not so much of industrial change as Kłoskowska suggests, but rather of the assimilationist strategy. Further conflicting findings were provided by the 1974 OBOP study on the proper role of women (Sokołowska, op. cit.). The majority of respondents (61 per cent) favoured paid work for women outside the home; of these about two thirds considered that domestic tasks should

combine gainful employment with full responsibility for running the home. At the same time, most respondents of both sexes thought the care of children to be the exclusive task of the woman. Only 27 per cent thought that a mother and father were equally responsible for taking a sick child to the doctor, while only 24 per cent thought that either mother or father should stay at home to look after a sick child (ibid.).

The Sexual Division of Labour

Regardless of the extent to which the value of sexual egalitarianism is espoused, all the evidence points to the fact that in Poland as in Britain, women remain the primary domestic workers and carers, and paid employment has made little difference in this respect. Martin and Roberts (1984) found that 54 per cent of British women working full time were combining paid work with the major share of housework at home, also noting that this is probably an underestimate of women's share of domestic work, since many women seemed to feel that tasks were being shared equally if they did a comparable amount while both were at home, even if the wife did other work during the husband's absence. In Poland a major time-budget study of three groups of unskilled female workers carried out during the sixties found that just getting married caused a greater increase in domestic duties than even the birth of a woman's first child (Strzemińska, 1970). Single saleswomen spent two hours per day on domestic tasks; married but childless women, four hours per day. Married women

with children had the longest hours of work at home, usually accompanied by a decrease in time devoted to employment, since women then tended to avoid extra work, to get a job nearer home, etc. The women in the sample who had children under six received some kind of help from their husbands in 22 per cent of cases, but 40 per cent of women with children under 13 had no help at all at home.

A comparison of the more recent and detailed Polish time budget data in Table 4.3, with the findings in Table 4.4 of Hunt's (1975) British study of the "formulators" and "implementors" of personnel policy at 223 large firms - over 100 men in high managerial positions - indicates the very small contribution made by men to the domestic division of labour in either country. This includes the contribution made towards shopping and the preparation of meals. These are particularly burdensome tasks in Poland with its unstable home market. Evidence from a questionnaire study carried out by the Institute of Home Trade and Services (IHWiU) indicates that shopping may be more time-consuming than the data in Table 4.2 suggest. The study involved 1,952 respondents in 134 foodshops in Warsaw and Łódź and found that on average, people spent 6-12 hours per week looking for and buying food, excluding the time taken to reach shops (Rada d/s Rodziny, 1980a). Twenty one per cent of respondents spent 60-120 minutes per day actually buying food, and another 15 per cent devoted over 120 minutes per day to the same activity.

TABLE 4.3: Time taken for tasks around the house by sex and by social group (Poland, 1976).

Nature of Task	Total		Urban		Rural		Men		Women				Private Farmers		Pensioners	
									Total		Married with children					
	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%
Preparation of meals	0:57	25.9	0:57	25.6	0:56	25.7	0:08	9.3	1:34	29.1	1:52	29.3	1:09	28.1	1:09	24.2
Washing up; cleaning	0:39	17.9	0:40	18.0	0:37	17.0	0:05	5.8	1:04	19.9	1:11	18.6	0:45	17.5	0:50	17.5
Washing; ironing	0:25	10.5	0:22	9.9	0:24	11.0	0:02	2.3	0:40	12.4	0:52	13.6	0:29	11.8	0:22	7.7
Sewing; mending; knitting	0:16	7.3	0:15	6.7	0:17	7.8	-	-	0:28	8.7	0:28	7.3	0:22	8.9	0:24	8.4
Care of children/elderly	0:25	11.4	0:25	11.2	0:26	11.9	0:15	17.4	0:34	10.6	0:53	13.9	0:25	10.2	0:21	7.3
Lighting/stoking of stoves	0:09	4.1	0:07	3.1	0:12	5.5	0:12	14.0	0:07	2.2	0:07	1.8	0:13	5.3	0:15	5.2
Repair/maintenance of household equipment	0:05	2.3	0:06	2.7	0:05	2.3	0:10	11.6	0:01	0.3	0:02	0.5	0:04	1.6	0:10	3.5
Shopping	0:27	12.2	0:34	15.2	0:19	8.7	0:13	15.1	0:37	11.5	0:40	10.5	0:19	7.7	0:45	15.8
Use of services for household needs	-	-	0:01	0.4	-	-	-	-	-	-	-	-	-	-	0:01	0.3
Other tasks	0:19	8.6	0:16	7.2	0:22	10.1	0:21	24.5	0:17	5.3	0:17	4.5	0:22	8.9	0:29	10.1
Total	3:40	100	3:43	100	3:38	100	1:26	100	5:22	100	6:22	100	4:06	100	4:46	100

Source: GUS figures reproduced in Rada d/s Rodziny (1980a), Table 1A.

TABLE 4.3: Time taken for tasks around the house by sex and by social group (Poland, 1976).

Nature of Task	Total		Urban		Rural		Men		Women				Private Farmers		Pensioners	
									Total		Married with children					
	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%	Hrs/Min	%
Preparation of meals	0:57	25.9	0:57	25.6	0:56	25.7	0:08	9.3	1:34	29.1	1:52	29.3	1:09	28.1	1:09	24.2
Washing up; cleaning	0:39	17.9	0:40	18.0	0:37	17.0	0:05	5.8	1:04	19.9	1:11	18.6	0:45	17.5	0:50	17.5
Washing; ironing	0:25	10.5	0:22	9.9	0:24	11.0	0:02	2.3	0:40	12.4	0:52	13.6	0:29	11.8	0:22	7.7
Sewing; mending; knitting	0:16	7.3	0:15	6.7	0:17	7.8	-	-	0:28	8.7	0:28	7.3	0:22	8.9	0:24	8.4
Care of children/elderly	0:25	11.4	0:25	11.2	0:26	11.9	0:15	17.4	0:34	10.6	0:53	13.9	0:25	10.2	0:21	7.3
Lighting/stoking of stoves	0:09	4.1	0:07	3.1	0:12	5.5	0:12	14.0	0:07	2.2	0:07	1.8	0:13	5.3	0:15	5.2
Repair/maintenance of household equipment	0:05	2.3	0:06	2.7	0:05	2.3	0:10	11.6	0:01	0.3	0:02	0.5	0:04	1.6	0:10	3.5
Shopping	0:27	12.2	0:34	15.2	0:19	8.7	0:13	15.1	0:37	11.5	0:40	10.5	0:19	7.7	0:45	15.8
Use of services for household needs	-	-	0:01	0.4	-	-	-	-	-	-	-	-	-	-	0:01	0.3
Other tasks	0:19	8.6	0:16	7.2	0:22	10.1	0:21	24.5	0:17	5.3	0:17	4.5	0:22	8.9	0:29	10.1
Total	3:40	100	3:43	100	3:38	100	1:26	100	5:22	100	6:22	100	4:06	100	4:46	100

Source: GUS figures reproduced in Rada d/s Rodziny (1980a), Table 1A.

TABLE 4.4: Tasks done around the house by married men (%) (Britain, 1973)

	Proportion of task done by husband					Not Stated
	None	One Quart	About One Half	More than One Half	All	
Formulators						
Preparing, cooking meals	52.4	38.4	6.3	0.2	-	2.7
Washing up	27.8	53.1	11.0	1.8	3.3	3.0
Washing, ironing, mending	85.2	11.0	0.4	0.2	-	3.3
Other housework	57.7	32.1	6.7	0.2	-	3.3
Care of children	52.8	35.0	8.7	0.6	-	3.9
Shopping, errands	40.7	34.8	16.7	1.8	0.2	5.8
Household decorations, repairs	24.0	13.0	11.8	16.3	31.3	3.6
Gardening	11.0	8.1	25.4	16.7	35.2	3.6
Other tasks	83.9	4.5	0.4	-	4.1	7.1
Proportion of all tasks	1.4	73.8	17.1	-	-	7.7
Implementors						
Preparing, cooking meals	58.3	32.5	6.8	0.2	0.4	1.8
Washing up	25.2	46.3	17.6	2.6	6.8	1.5
Washing, ironing, mending	85.8	11.8	0.6	0.2	-	1.5
Other housework	56.0	28.9	13.2	0.2	-	1.8
Care of children	67.4	26.3	4.4	0.6	-	1.3
Shopping, errands	35.8	29.9	25.0	5.2	0.2	3.9
Household decorations, repairs	22.2	10.3	16.2	11.4	37.4	2.5
Gardening	9.1	8.3	21.9	15.5	42.7	2.5
Other tasks	89.7	1.4	-	-	4.4	4.5
Proportion of all tasks	1.5	72.1	18.7	1.1	-	6.6

Source: Hunt (1975), reproduced in Ungerson (1983), Table 2.1, p. 37.

When Polish men do become involved in child care, it is usually in the form of recreational activity (see Tables 4.5 and 4.6), a fact which has been ascertained in the case of Britain by Oakley (1974).

TABLE 4.5: Percentage of mothers and fathers performing particular child care tasks with respect to children under 7. (Poland)

Nature of Task	Mother	Father
Help children to get up, wash, dress	77.8	4.6
Supervise meals	75.7	2.7
Take children to nursery or nursery school	18.1	4.6
Play with children	61.2	18.8
Take children for walks	55.4	16.8

Source: Piotrowski, J. (1969).

TABLE 4.6: Proportion of day spent on direct interpersonal contact with children by social group.

	Mothers		Fathers	
	2 parent families	1 parent families	2 parent families	1 parent families
Peasant	0.42	0.20	0.06	0.24
Mixed Income	0.56	0.48	0.56	0.48
Worker	0.43	0.25	0.43	0.25

Source: Compiled from Adamczuk, L. (1979), Tables 2, 3 & 4, pp. 29-30

If a woman is employed, a family member often may help to look after the children, although this is more likely to be the child's grandmother rather than his or her father, as may be seen in Table 4.7 and 4.8. In general British studies have pointed to the fact that few fathers take a regular part in looking after their children (Newson and Newson, 1963; Richards, Dunn and Antonis, 1977;

TABLE 4.7: Care of children under 4 by educational level of mother. (Poland, 1976).

	Total		Educational Level					
			Higher	Further (policealne)	Incomplete Higher	Secondary	Basic Technical	Other
	Number	%	%					
Total	1,224	100	100	100	100	100	100	100
Mother	463	37.8	32.3	37.7	44.4	35.2	47.1	55.6
Mother/Father	100	8.2	6.8	7.7	12.7	6.3	13.2	18.1
Grandmother	312	25.5	25.5	24.6	22.2	26.7	28.9	12.5
Other relation	47	3.8	3.6	3.9	1.6	4.2	2.5	4.1
Paid childminder	178	14.6	26.6	14.6	12.7	14.4	3.3	4.1
Day nursery/Creche	124	10.1	5.2	11.5	6.4	13.2	5.0	5.6

Source: GUS figures presented in Kuciarska-Cieslelska, M. (1979), Table 3, p. 40.

TABLE 4.8: Arrangements made by full and part-time workers for care of pre-school and school age children during term time (Britain, 1980).

Type of arrangements	Women who make arrangements for pre-school children*			Women who make arrangements for school children in term time*		
	Full time	Part time	All working women	Full time	Part time	All working women
	%	%	%	%	%	%
Husband	13	50	47	44	63	57
Child's older brother or sister	4	3	4	13	9	10
Child's grandmother	44	24	34	28	24	25
Other relative	4	10	9	12	9	10
Childminder (in her home)	23	11	16	7	4	6
Person employed in informant's home	6	2	4	4	2	3
Friend or neighbour on exchange basis	3	3	3	10	8	9
Day nursery or creche run by employer	3	1	1	-	-	-
Day nursery or creche run by local authority and social services	3	2	2	-	-	-
Private day nursery or creche	3	1	1	-	-	-
State nursery school or class	4	3	4	-	-	-
Private nursery school	1	1	1	-	-	-
Playgroup	3	3	3	-	-	-
Other arrangements	-	-	-	4	3	3
Base	66	160	226	196	353	549

* Some women made arrangements for both pre-school and school children. Percentages do not add to 100 because some women made more than one arrangement.

Source: Martin, J. and Roberts, C. (1984), Table 4.10, p. 39.

McGlaughlin, 1981; Osborn, Butler and Morris, 1984), but fathers do sometimes look after pre-school and school age children where the mother is employed in part-time work (Table 4.7). In Poland, the help of kin in this respect is particularly important in the case of lone mothers, as may be seen in Table 4.9.

TABLE 4.9: Forms of care for children under 15 by marital status of mother and number of dependent children in worker households (Poland, 1983).

	Total (n=4765)	Lone Mothers: Number of Children				Married Women: Number of Children			
		1	2	3	4+	1	2	3	4+
Children receiving care from:		%							
Day nursery/Creche	1.5	1.7	3.0	2.7	-	2.2	1.9	0.6	0.2
Nursery school	11.2	13.7	13.1	2.7	-	14.3	13.1	6.4	6.7
After school club	5.3	12.0	6.1	13.5	-	4.1	5.6	5.8	1.9
Family member	10.9	21.4	25.3	5.4	-	12.0	10.5	8.0	9.6
Paid childminder	0.5	1.7	-	-	-	1.0	0.7	0.1	-
Mother on paid child care leave	14.6	7.7	2.0	8.1	-	14.6	14.9	15.2	17.8
Mother on child care leave (with no benefit, i.e. family p.c. income > 3,600 zł)	3.8	-	-	-	-	4.0	3.6	4.5	5.5
Mother not employed and not on child care leave	22.9	5.1	2.0	-	-	17.9	21.6	28.6	37.8
Employed mother	26.2	33.3	48.5	64.9	83.3	25.5	25.5	26.7	17.6
Other form of care	3.3	3.4	-	2.7	16.7	4.4	2.6	4.1	2.9
Total	100	100	100	100	100	100	100	100	100

Source: GUS (1983), Table 17, p. 25.

As far as the day care of pre-school children is concerned, according to the data in Table 4.7, 9 per cent of British mothers who were employed full-time had arranged for their children to be looked after in some form of day nursery or crèche; just over 10 per cent of Polish children enjoy this kind of care (Table 4.7). However, private paid arrangements are more common in Britain than in Poland, the extent to which this option is utilised in Poland being closely

related to the educational level (and hence also income level) of the mother.

Conclusion

It is hard to avoid the central conclusion to emerge from this chapter. It is that, despite the large-scale political and economic differences which separate Poland and Britain, the division of labour within the home remains remarkably the same, although the way in which public and private roles interlock may differ. Women are the primary, often sole, domestic workers and the rearers of children. There are no Polish findings which can conclusively indicate a shift away from a traditional division of labour, and certainly no trace of any change to match the scale of the socialisation of the means of production, or the mass employment of women.

There is nothing in British official ideology which would contradict such domestic arrangements. In Poland, however, ideology has been more equivocal, enunciating sexual equality (including sexual equality within the family) as a fundamental principle on the one hand, yet ensuring on the other that state interests remain paramount. In both Poland and Britain, the interests of the state may lie in sexual inequality, with certain caring tasks being carried out at less cost within the private domain. This situation has in Poland been accompanied by a certain confusion in attitudes towards women and sexual egalitarianism.

The prevalence of full-time work for women, both in private agriculture and in employment, together with the particularly burdensome nature of some domestic tasks, e.g. shopping or, specifically in the case of some Łódź textile workers, the carrying of water up tenement staircases, means that the combination of public and private responsibilities - the earning of a livelihood with which to support one's children together with the physical care of these children - may reach the limits of endurance for some Polish women. This is of course particularly true of lone mothers who if not supported by kin, must provide for and look after their families alone (4).

However, the persistence of a traditional division of labour at the domestic level in the face of what are often the extreme pressures Polish women have to bear, indicates that this is a resilient and in some respects irrational aspect of social organisation and culture perpetuated at one level by individuals. This also has to be understood in its political context. The family in Poland is a nucleus of resistance vis-à-vis a state which has not established legitimate authority. As such, it is perceived to be in the interests of both men and women as citizens that the family should be strong. Thus the state is commonly identified by women as being responsible for their extreme physical burdens (a) because it has obliged women to take up paid work in the public domain and/or (b) because the task of running a house is so demanding when goods and services are hard to come by, or are of poor quality. There is little challenge from any quarter, however, to the traditional domestic division of labour.

Notes

1. An important anomaly present in the 1944 Soviet Family Code was vitiated by according the same status to legitimate and illegitimate children, and by affirming the equal rights and duties of both parents - whether or not they are married - in respect of their children.

2. Zarządzenie Ministra Zdrowia z dn. 13.01.53 (Nr. Z. III 348 & 573/52), Dz. Urz. Min. Zdrowia, 1.02.53, 3, Poz 17.

3. Trawińska (1981) has noted that apart from the numerous studies of the families of alcoholics which have been carried out in Poland, there has been no investigation of the 14 per cent of families which have a chronically sick or invalid member. Nothing is known of the burdens in terms of energy, time and finances which these families have to bear.

4. Since 1981, special child care benefit rates have been made available for single parents in Poland with respect to very young children; see Chapter V.

CHAPTER V

CHILD HEALTH AND SOCIAL POLICY

Introduction

A broader concept of health recognises that health needs are not simply medical needs, but comprise, amongst others, important social and welfare aspects. This chapter examines the role played by state welfare provision as this affects child health, and concentrates on the detail of provision in a number of relevant policy areas. The approach accepts that formal provision must necessarily be seen in the wider context of how the societies function to produce and ascribe welfare, but does not draw comparisons and conclusions in terms of a straightforward dichotomy between "capitalism" and "socialism". This would be to oversimplify and to mislead. Nor is a view of "convergence" espoused, although some basic similarities are noted. Foremost among these is the extent of ideological conflict embodied in both Polish and British social policy, which is discussed below. There are many factors, however, which place limits on the convergence thesis. Firstly, the legitimating arguments of the post-war Polish government involved the clear articulation of long-term social goals. Secondly, based as they were on Marxist-Leninist principles and presenting as they did a picture of social justice based firmly on equality, these goals were in large measure accepted by the Poles. On the basis of research carried out in the late fifties and sixties, Nowak (1981: 27) was able to write that

> "'the experiment in social learning on a national scale' concluded by the new regime had succeeded to a certain degree. The great changes in the social and economic organisation of the society - the nationalisation of industry, land reform, economic planning, the abolition of the pre-war class structure - were accepted by the people."

Thirdly, the Polish government has increasingly suffered from a crisis of legitimacy. To some extent, it has created an "ideological trap" for itself (Staniszkis, 1979), inasmuch as it is rejected in terms of its own legitimating arguments. Fourthly, there has in Poland been an historical absence of capitalist relations of production and fifthly, it has a particular national history of repeated foreign occupation under the Partitions. Together, these factors have created a psycho-social environment which differs radically from that in Britain and differs dramatically, moreover, in terms of the implications it has for potential for action. It is here, for example, that we should look for an explanation of why the development of social security is seen in Britain as having a role to play in preserving a compliant working-class, while in Poland the decade which saw the most rapid development of social policy provision, the seventies, also saw a widening of social inequalities - particularly in wages and housing (Malanowski, 1981), and an increasing public awareness of this culminating in working-class rebellion in 1980. These psychological differences have a more direct bearing on the division of labour in child health, particularly with regard to the psychology-based professions, as we shall see from the consideration given in this and the following chapter to the role of social workers, health visitors, child-rearing experts and applied psychologists in child health care.

Themes in Welfare Provision

What George and Manning have stated in relation to the Soviet Union holds true also in the case of Poland, namely that there is "a socialist form of ownership of the means of production but that capitalist elements still dominate its system of income and goods distribution as well as its administrative structures in government and work" (George and Manning, 1980: 28). At the same time the "socialist" countries operate within the context of a single world economy, a capitalist world system, co-operating with the Western economies in arrangements such as international subcontracting, management, supply and licence agreements (Fröbel et al., 1980), and with Western banks in loan agreements which also undoubtedly involve if not direct then indirect constraints on internal policies. While there has been in Britain an "uneasy compromise" between liberal and collective values (George and Wilding, 1976) ever since organised labour challenged the liberal values of her market economy - resulting in paralysing ambivalence with regard to social policy, in Poland too conflicting ideologies and values co-exist. Her command economy is based on a Taylorist division of labour; official collective and egalitarian ideology (itself at times modified, especially during the 1970s) overlays practice shot through with market values, e.g. private medical practice over which the government has consistently failed to adopt an official stance (Sokołowska, 1972), extensive and expensive private day care for children, the giving of bribes, now widely considered to be a "rational" form of behaviour according to research carried out by Kutyłowski and Rzepliński (Falkowska, 1980). Maria Łoś (1980b) has hinted at the existence of an alternative capitalist ideology in

Poland, while Hilda Scott (1978) writing of Czechoslovakia points to the importation of capitalist values along with capitalist technology in her attempt to explain the persistence of the male-dominated gender order in that country.

The British welfare state was founded on principles of comprehensiveness, and in order to achieve this, a degree of unification of administrative responsibility. William Beveridge's plan as laid out in the Beveridge Report of 1942 was intended to be "universal in coverage of both risks and persons and would provide subsistence benefits for all" (Fraser, 1981: 199). In the event, not all categories of risks and persons were provided for. There was a failure from the outset to recognise the problems of one-parent families, for instance, while women, particularly married women, found themselves excluded from a wide range of provisions. Nevertheless, July 1948 saw the introduction of the National Insurance, Industrial Injuries, National Assistance and NHS Acts, while the poverty studies of the sixties brought simultaneous changes to legislation governing supplementary benefit and national insurance unemployment benefit. Within this institutional framework, the 1970 Conservative government departed further from the universalism of previous policy, introducing selective and means-tested measures such as the Family Income Supplement (FIS) which was aimed at low-income families.

On the Polish side, universalism and collectivism have been more unequivocal features of the dominant ideology, and although it would be true to say that various forms of welfare legislation have been extended over the post-war period to include widening population

groups, selectivity remains an important element of welfare provision. However, along with the trend to wider inclusion there has also been a persistent and increasing tendency to use welfare benefits as a political reward. Progress towards the removal of some forms of selectivity has been seen as unduly slow; this is true for example of the social policy distinction between white- and blue-collar workers, with the latter not receiving equal sickness and maternity benefits until 1975. Prior to that date, sickness and maternity benefits for manual workers had been only 30 per cent or 50 per cent of wages. In other areas, benefits remain tied to employment status - married women who have never been employed in the state sector have as yet won no recognition of the domestic and child-rearing tasks they perform in the shape of an entitlement to a pension in their own right (Radziński, 1981). Other "fringe" benefits such as free school meals are means-tested and are not available as a matter of course. Elsewhere again, policy innovations have involved the introduction of selectivity. The 1970 and 1981 modifications to child allowance legislation entailed the addition of an earnings-related component while separate rates still adhere to particular occupational groups, notably the military and the militia; in 1972 a separate pension scheme was introduced for the political and state elite only (ibid: 3). Furthermore, a much-contested clause inserted into the 1976 Constitution makes all civic rights conditional on political status - "the enjoyment of rights (becoming) dependent on the citizen's fulfilment of his obligations with respect to the state" (Lipski, 1983: 23).

In the area of risks covered, Polish policy has been characterised

by a recognition of the interdependence of production and reproduction (as far as the state-socialised sector is concerned), but with a failure to provide guaranteed subsistence through adequate income maintenance policies. The refusal of British policy to face the fact that according to the 1979 GHS only 20 per cent of economically active married men supported a dependent wife and children (Land, 1983), is matched by the refusal of Polish policy-makers to admit that the ideological claim that social welfare would flow from the process of production itself has turned out to be manifestly untrue for a section of those employed in the state sector, not to mention those who for one reason or another fall outside the labour market. The evidence presented in Chapter III has given some indication, albeit an underestimate, of the nature and extent of this diswelfare. The figures in Table 3.1 show, for example, that approximately 8 per cent of those employed in the state sector, 20 per cent of private peasants and 30 per cent of pensioners, together constituting 14 per cent of the population, were below the 2,000 zł. poverty line in 1981, while Deniszczuk (1981b) has calculated that 40 per cent of Polish children live in poverty. Employment does not, of course, ensure welfare in Britain either, as the figures shown in Table 3.4 indicate.

The lack of a unified approach to welfare policy in Poland has resulted in and derives from a lack of administrative unity at central and local levels, despite conditions which compare favourably with those in Britain for a comprehensive approach. The divisions of central responsibility for child health and welfare in Poland is indicated below (1).

1. The Ministry of Health and Social Welfare (MZiOS).

The MZiOS is responsible for administering health care to pregnant women, infants and children, in addition to other population groups. It also organises nurseries and other forms of care including institutional care in children's homes and fostering - in all cases for children under three years of age. It may also act as a source of social assistance for families in need, but its activities in this regard are marginal and focused mainly on the elderly.

2. The Ministry of Education (MOiW).

The Ministry is charged not only with the education sensu stricto of the young (i.e. children and young people between the ages of 3 and 18 years), but also their welfare in a general sense. In addition to organising education at a primary and secondary level, it is concerned with after-school care, schoolchildren's hostels and a school meals programme. It organises and runs children's homes and residential "special schools". It administers the fostering of children in the relevant age group and engages in limited social assistance for the families of children in need. It is also the co-ordinator of colony and camp holidays for schoolchildren.

3. The Ministry of Labour, Wages and Occupational Welfare (MPPiSS).

This Ministry draws up regulations concerning the benefits available to working women as these relate to pregnancy, childbirth and child-rearing. It has developed a system of insurance benefits which have a direct effect on the child's welfare in his/her own

family. These notably involve sickness and maternity benefits, birth grants, child care allowances, and other benefits such as the alimony fund and aspects of occupational welfare which will be the subject of a later section. It lays down the guidelines for occupational welfare (which again has a residual social assistance element) and for the financing (with enterprise funds) of crèches, nursery schools, after-school clubs and colony camps and holidays.

4. The Ministry of Justice.

The Ministry is empowered, through the Family Court, to deprive parents of custody of their children, placing them in institutional care. It names guardians and arranges adoptions. It also has a social assistance function in that it administers benefits to the families of prisoners and "post-penitentiary benefits" to ex-convicts.

5. The Ministry of the Interior, Ministry of Communications, Ministry of Agriculture and Ministry of Defence.

These Ministries are additionally responsible for the central administration of health services and/or crèche and nursery school facilities for the personnel in their respective sectors.

6. Other Agencies.

Social assistance may also be provided directly from state funds through local government, through state-subsidised voluntary associations and, until their dissolution in 1981, through the Trades Unions.

In contrast to this picture, social security in Britain is the responsibility of a single central agency: the social security section of the DHSS. Yet the functions and methods of working of the three DHSS sections, social security, health and personal social services, remain quite distinct. Outside the DHSS, there are several other Departments which share responsibility for providing services for the socially disadvantaged. The Court Report (HMSO, 1976) stressed the importance for child health of multidisciplinary working, and the Morris Report (Morris, 1980) recommended that research should be undertaken to discover ways in which such co-operation might be effected. The various central Departments in question, apart from the DHSS itself, are (a) the Department of Education which provides matching funds for local authorities to assist inner city schools; (b) the Home Office which co-ordinates volunteer work, much of it for the deprived; (c) the Department of the Environment which provides funds for the Urban Aid Programme, and (d) the Manpower Services Commission which contributes to schemes for young people to work in hospitals and social services, where much of this work involves the support of families with young children particularly vulnerable to ill-health (see Morris, ibid.: 22).

The lack of a comprehensive and consistent conceptualisation of social policy in Poland is reflected also in the history of post-war policy development there. The period up to the middle fifties was one dominated by economic policies and planning (Haavio-Mannila and Sokołowska, 1978). Ferge (1979) has noted a similar phenomenon for Hungary. The period also showed prolific health legislation, a response to the needs of industrial mobilisation and for improvement of

the nation's biological base. Infant feeding programmes and the distribution of benefits such as layettes on the birth of a child were dealt with through this legislation as was the prioritised creation of crèches and nurseries to allow mothers to continue employment. This was not, however, regarded as social policy; health and social policy have yet to be integrated, (Sokołowska, 1974), as is the case in Britain. A period of quiescience was followed in the 1970s by a spate of legislation and the official coinage of "social policy" as such. These largely represented an extension of employment-related benefits (together with the introduction in 1978 of the universal birth grant), many of which were geared to an institutionalisation of women's "dual role" and were accompanied by a heavily familial rhetoric. While variously presented as aiming for social equality, the "proper structuring of comsumption" and "the good of the family", many of the policies in question (extensions of maternity and sickness leave and benefit, extensions of child care leave, changes in the labour code regarding pregnant and breast-feeding women) obviously have an eye to the need to secure an adequate labour supply both in the present (the employment of women), and in the future (the pro-natalist dimension). What was new about them was the familialism in which they were couched, together with the fact that, taken in conjunction with the failure to develop the nursery and crèche system beyond a symbolic level and the failure at all times to consider intra-familial role changes, they effectively welded women to their child-rearing roles.

The changes in the form and content of policy over time can be compared to some extent with changes in official attitudes towards

the family and towards women which have been observed by many writers (Kłoskowska, 1962; Dodziuk-Lityńska and Markowska, 1975; Haavio-Mannila and Sokołowska, 1978). In particular, Haavio-Mannila and Sokołowska (ibid.) have shown how different policies have been associated with changing media models of women's position in Polish society, and how this in turn has been associated with female employment:

1) 1947-54 a desire to maximise mobilisation of female labour; the role of women as members of socialist society stressed;
2) 1955-57 (a period of redundancy for female labour) - a new model of women's family role projected, reducing at the same time vocational and professional roles;
3) 1958 - late sixties - harmonisation of both viewpoints;
4) 1970s - pro-natalist policies; limitation of employment of certain groups of women for demographic reasons.

The authors note that at the time of writing, "a still newer pattern is beginning to emerge which is marked by the growing availability of individual options" (p. 195), while in the same volume Jallinoja et al. indicate that private child day care provision in Poland (mini-nurseries and child-minding run along private enterprise lines) in fact exceeded public nursery provision, catering for 20 per cent and 16 per cent of the relevant age group respectively (Jallinoja, et al., 1978: 323). For such a key policy in terms of socialist ideology, pro-natalism and high female employment, the provision of socialised child day care in Poland remains lowest among all the East European countries, with the level of such care being uncorrelated with the level of female employment in these countries (Scott, 1979).

Family Maintenance

A fundamental normative difference in maintenance responsibilities in the two countries, is the elaborate system of family maintenance embodied in Polish family law (Lasok, 1968), which may be regarded as an instrument of social policy since to some extent family maintenance is expected to perform functions which in Britain would be performed by social security and the personal social services (2). Maintenance claims may be either absolute, as in the case of children in respect of their parents, or conditional, depending on the financial circumstances of both claimant and the person from whom maintenance is claimed, and the rate of litigation tends to be high (ibid.). In part, the state interprets its constitutional undertaking to secure minimum subsistence for all citizens as the enforcement of family maintenance (3) through the courts or by direct salary transfer.

Nevertheless in practice the state in both Britain and Poland does make a financial contribution, however symbolic, to enable parents to carry out their maintenance responsibilities with regard to their offspring, most notably in the form of child allowances and various forms of social assistance.

Child Allowances

The Family Allowance was introduced by the British coalition government in 1945. This had been preceded by a lengthy period of debate dating from the beginning of the century. Recruitment for the Boer War in 1899 had revealed the poor state of the nation's health, and had led to the 1904 Physical Deterioration Committee Report and the institution of measures designed to reduce infant mortality and improve child health. The idea of the Family Allowance in this context seemed a possible way of alleviating poverty without undermining wage incentives. Infant mortality was commonly viewed at this time in terms of a "failure of motherhood"; feminists, led by Eleanor Rathbone, used this emphasis on motherhood to press home demands for family allowances as a measure which would allow women to perform their duties as mothers better (Lewis, 1980). Rathbone propounded a theory of motherhood as service to the community, and her demand for the Family Allowance was closely allied to the idea of equal pay for men and women (Wilson, 1977). The argument was that men's larger wage, the so-called "family wage", should be replaced by a "living wage", that is, equal pay for men and women where the situation of families with and without children would be equalised by the Family Allowance. Although the domestic role of women was not itself challenged, Rathbone nevertheless argued unswervingly for the separation of motherhood and marital dependency for women (ibid.).

In the event, family allowances when they were introduced "were more a part of the government's wider economic strategy than

a conscious attempt to broaden maternal and child welfare policy" (Lewis, op. cit.: 14); moreover, they did not become payable to mothers until April 1977. In Beveridge's eyes, this was an instrument which would encourage women to play an active reproductive role in Home and Empire, as the following quotations indicate.

> "Children's allowances can help to restore the birthrate both by making it possible for parents who desire more children to bring them into the world without damaging the chances of those already born, and as a signal of the national interest in children setting the tone of public opinion."
>
> "The attitude of the housewife to gainful employment outside the home is not and should not be the same as that of the single woman. She has other duties ... Taken as a whole the Plan for Social Security puts a premium on marriage in place of penalising it ... In the next thirty years housewives as mothers have vital work to do in ensuring the adequate continuance of the British Race and of British Ideals in the world."
>
> (Beveridge quoted by Wilson, 1977: 151-152).

Although Beveridge proposed that the level of family allowances should be set at the subsistence cost of a child (and assumed that wages would be sufficient to support a married man with one child), his proposal of 40p was reduced to 25p by the coalition government (Land, 1977), on the assumption that free school meals would be available to all schoolchildren. First-born children were initially excluded, but this was subsequently amended.

Child allowances were introduced in Poland in 1948, and in some ways were designed to meet the purpose which Eleanor Rathbone had foreseen for the Family Allowance in Britain. In a context of

officially prescribed equal pay for men and women, child allowances in Poland were meant as

> "an indispensible supplement to low earnings which would assure every family a decent subsistence level and help to equalise children's opportunities and conditions for development" (Balcerzak-Paradowska, 1980: 5).

They were not associated with pro-natalist or domesticating aims and were available for all children within a family and for non-employed spouses, though rates were low.

In both countries modifications were introduced in the early seventies involving a means-test component. In Poland this entailed the introduction in 1970 of a two-tier system with rates dependent on per capita monthly income, an implicit "poverty line", and the introduction in Britain in 1971 of the Family Income Supplement, a means-tested benefit for low income families administered by the DHSS on behalf of the SBC. Though subject to consecutive increases, the real significance of child allowances and benefit has fallen steadily in both Britain and Poland during the post-war years. According to figures given by Lynda Chalker (then a junior Minister at the DHSS), in a written reply to a parliamentary question in 1981, the value of child benefits (formerly family allowance and child tax allowance) fell for the three child family from 25.8 per cent of average earnings in 1950 to 12.2 per cent in January 1981 (New Society, 1981). Polish child allowances fell from 34.9 per cent of average wages in 1950 to 16 per cent in 1978 for families with three children (Graniewska, 1980). As a proportion of the GNP, expenditure on child allowances in Poland fell from 2.8 per cent in 1960 to 1.9 per cent in 1966 to

0.8 per cent in 1978 and 1979 (Balcerzak-Paradowska, op. cit.: 19).

During the 1970s child allowance eligibility was gradually extended in Poland to groups beyond those employed in the state-socialised sector, culminating in the extension of eligibility rights to the private peasants on January 1st, 1980 (4). In the 1970s also, special concern was expressed for the plight of large families (i.e. with 3 or more children), which predominate among the poor, and in which 35.3 per cent of the nation's children live, according to the Polish national census of 1978 (Rada d/s Rodziny, 1981).

> "... In social policy the Party will pay special attention to the further improvement of the living standards of large families. The general increase in benefits should serve this end, especially in the case of families in difficult material circumstances"
>
> (Resolution of the VII Party Congress, ibid.: 12).

But as a form of compensation for families with children, especially for families with three or more children, the impact of child allowances has been slight as can be seen from Table 5.1.

TABLE 5.1: The effect of Child Allowance on Family income by number of children (Poland, 1978).

	Number of children				
p.c. income:	0	1	2	3	4+
including child allowance (%)	100	73 6	56.4	44.3	35.9
excluding child allowance (%)	100	72.9	55.0	41.7	31.9
Effect of child allowance (%)	-	0.7	1.4	2.6	4.0

Source: Balcerzak-Paradowska, B. (1980), Table 16, p. 30 (computed on the basis of unpublished GUS figures).

According to these data, their effect was to raise p.c. income in 1978 by 4 per cent for families with four and more children and by 0.7 per cent for families in a family with a single child relative to the income of childless families. The significance of these figures may be viewed in perspective when set beside the fact that each consecutive child in a family has been estimated to entail an average drop in per capita income of roughly 20 per cent (Balcerzak-Paradowska, op. cit.).

These are the data which substantiate Graniewska's recent conclusion that "... the child allowance system does not fulfil its compensatory and egalitarian role" (Graniewska, op. cit: 71). Suggestions have been made that in order to achieve these goals child allowance should be pegged to average incomes or to the normative cost of upkeep of children (Graniewska, op. cit; Balcerzak-Paradowska, op. cit.). Using the figures worked out by Deniszczuk which are presented in Table 3.5, Graniewska has estimated that the new 1981 (post-Solidarity) child allowance rates cover approximately 11 per cent of the cost of upkeep of children in a two-child family (at 1981 prices) (Graniewska, op. cit.: 72). The anomalies inherent in a two-tier system have also been indicated, whereby families just below the income threshold may receive an allowance three times as high as those just above the threshold, although earning differences are minimal (Balcerzak-Paradowska, op. cit.). Current rates are shown in Table 5.2.

TABLE 5.2: Child Allowance Rates in Poland (as of January 1st, 1981).

No. of children	Monthly allowance according to p.c. family income		
	under 1,600 zł.	1,600-2,000 zł.	above 2,000 zł.
1	250	160	70
2	600	410	175
3	1,050	750	310
4th and each consecutive child	500	300	155

Many of these faults are shared by the British child benefit system. Although now a flat-rate benefit, it makes a relatively small contribution to the cost of upkeep of children (5). The confusions and absurdities which have accompanied legislation in this area have been well documented by Land (1977). Clear to emerge here, as elsewhere, is the relative disjunction between official rhetoric in Poland and developments in social policy. While the familialism of public speech was growing to a crescendo in 1970s, the real value of child allowances, a key family policy, was steadily declining (6).

Beyond this, child allowances in Poland have had a clear labour discipline dimension which is articulated in the laying down of certain eligibility conditions (7). These were lifted following demands made by Solidarity although the separate and more favourable child allowance schemes for the militia and the military persist.

Social Assistance

Perhaps the greatest contrasts which can be drawn between social policy in Britain and Poland is in the area of social assistance. The idea of a national minimum has been central to social policy in Britain since the Poor Law, and in the post-World War II years has assumed ever-increasing importance due to the steep rises in unemployment for which Beveridge had not planned. No comparable scheme exists in Poland. In its place there is a much higher level of employment, a system of family maintenance and residual and highly fragmentary forms of social assistance.

The breadth and depth of needs which remain unmet within this system is hard to assess. The division of administrative responsibility in this area which was described earlier in the chapter means of necessity that there is no centralised and systematic collation of data on which to base an assessment of what these needs are. Voluntary organisations such as the Society of Children's Friends (TPD) who employ unpaid case-workers on the ground, have made continued representation to the authorities for the need to integrate and extend welfare services for the family if poverty is to be properly tackled.

> "We see a fundamental change in the material situation of families who cannot cope in bringing up their children, especially of lone mothers or large families where parents cannot maintain their children because of poor health, only coming about through some extension to the social welfare system"
>
> (Chmieleńska, 1979: 36).

The division of responsibility is, they say, "artificial, some forms are anachronistic and often even downright harmful to the family" (TPD, 1982a). Apart from the courts, there is no institution except the TPD itself which deals with the child as a whole. This is reminiscent of the situation in Britain where the voluntary associations which are family and child centred are concerned with a wide range of needs which cut across the statutory services's divisions between health, education, housing and social services.

Knowledge concerning the availability of benefits in Poland is generally poor (Szczepanowski et al, 1981), and the system is so complicated that not even those concerned to provide help know what exactly can be arranged where and for whom (TPD, op. cit.). (Few know, for example, that assistance for the families of alcoholics is available from the Anti-alcohol Committee (SKP), but only if the alcoholic is registered for treatment (Szczepanowski et al., op. cit.)). The lack of a consistent and universal criterion for social assistance eligibility often lends itself to an arbitrary and "creative" interpretation of regulations which is not subject to any overall control (TPD, op. cit.; Szczepanowski, et al., op. cit.).

These criticisms led to the creation in 1977 of an integrated municipal welfare service in the town of Koszalin (Tuora, 1981), and more recent proposals for a similar scheme in Gorzów Wielkopolski (Szczepanowski et al., op. cit.). The background to this innovation has been described as follows.

> "(Formerly) ... assistance was largely rendered to those who claimed it; it did not always materialise

> when it was most needed; it was often delayed and as a result did not help people to get out of a difficult situation quickly. Those who were not pushy, who were helpless or convinced that either no-one would help them or that they would manage by themselves, did not receive anything. Added to this, some situations where outside help is needed, are not catered for in the mass of rules regulating social assistance. Voluntary and state institutions which render assistance to the physically, economically and socially weak are scattered, and do not have adequate back-up in terms of finance, staff and equipment. New social phenomena such as the increase in one-parent families, or various forms of invalidity or social maladjustment, take them by surprise. The sporadic and discontinuous nature of social assistance, the limited and narrow range of help available from the voluntary and state institutions - all this leads to ineffective action, the results of which are 'the forgotten areas of society'"
>
> (Tuora, op. cit.: 38).

As this author indicates, the lack of an adequate system of social assistance has had important consequences for the growing numbers of one-parent families in Poland, where fatherless families now account for approximately 11 per cent of all families with dependent children under 24 (see Table 4.1). It is here that one "forgotten area", one group of the very poor, is to be found (see p. 99).

There are no special benefits for one-parent families in Poland; the earned income of the mother is expected to be the main source of income for the upkeep of her children and she is eligible under the same conditions as other mothers for maternity and sickness benefits. While unpaid child care leave was in operation it was available only to separated women - about 33 per cent of lone mothers - on the same terms as women in two-parent families (Miśko-Iwanek, 1981). Since

the introduction of paid child care leave in 1981, lone mothers have been eligible for double the normal benefit rates. The new Labour Code of 1974 discarded special protection for unmarried mothers, while in January 1975 a State Alimony Fund was introduced through which lone mothers heading families with a per capita monthly income of below 1,400 zł. were enabled to claim maintenance for their children if this was not forthcoming from the father. The fund was largely created through subsidy from State funds (67 per cent), the remainder being made up by monies reclaimed by ZUS, the State Insurance Agency which administers the fund, from the recalcitrant fathers. It is empowered to pay out up to 500 zł. per month per eligible person; the average monthly amount rose from 410 zł. in 1975 to 463 zł. in 1979 (Graniewska, 1980). In addition to this, lone mothers are eligible for special loans from their work-place (50 per cent non-returnable), and are formally accorded priority in the allocation of child day care places, free school meals and a variety of occupational welfare benefits.

Research has shown that these arrangements do not work out as well in practice as might be hoped. In a study of 248 fatherless families carried out in 1978, it was found that only 60 per cent of children attended after-school clubs, and only one in three children ate school dinners. "Trying to arrange free dinners for their children was judged by the lone mothers to be too complicated and even humiliating" (Miśko-Iwanek, op. cit.: 142). Moreover, only 11 out of the 33 children under three years of age attended day nursery, while 44 out 58 children aged between 3 and 6 years attended nursery school. In her study, Jarosz (op. cit.) found a large number of lone mothers

in abject poverty who were quite unaware of their eligibility to claim from the State Alimony Fund, although the existence of the fund had been widely advertised in the mass media.

The effect of the Alimony Fund as with the alimony system in general, has been to provide sharply decreasing sums for each consecutive child in a family which in turn increases the probability that larger fatherless families, maintained as they are in any case by on average 40 per cent of a family wage (see p.64) will descend below subsistence level. This is surely at least a partial explanation of the under-representation among divorcing couples of those with two or more children relative to married couples as a whole and illustrates how lack of State support enforces the carrying out of certain functions within the family. The British situation is rather different in this instance, there being no difference in the distributions of family size among divorcing couples and couples in general (8). The relevant figures for Poland and Britain are shown in Table 5.3 and plotted in Figure 5.1.

Although one-parent families represent about one in eight of families with children in Britain, they accounted for just over 40 per cent of families receiving Family Income Supplement in December 1983, and at the end of September 1980 had accounted for about half of all families with children housed in England under the 1977 Housing (Homeless Persons) Act (Hansard, 16.5.84; NCOPF, reprinted in NCH, 1984).

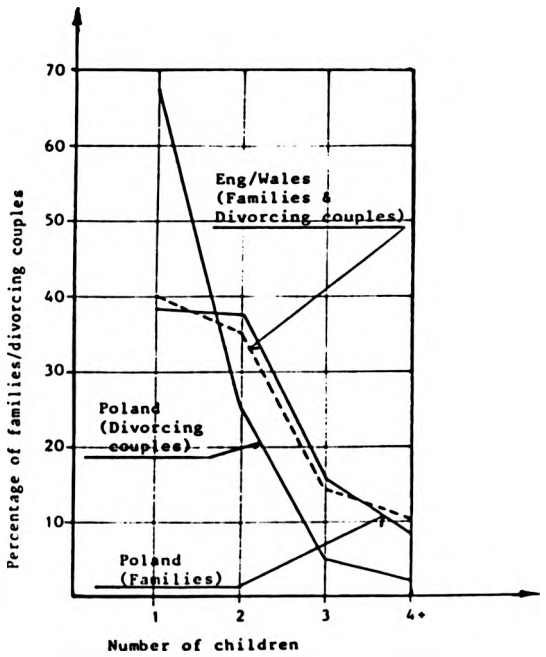
TABLE 5.3 and FIGURE 5.1: Divorcing couples with children and all families with children, by number of children (Poland & Eng/Wales)

Number of children	POLAND		ENG/WALES***	
	Divorcing couples with children (1974)*	Families with children (1974 Microcensus)**	Divorcing couples with children (1974)	Families with children (1971 10% sample)
	%	%	%	%
1	67.4	39.9	38.5	38.1
2	25.3	34.8	37.6	37.5
3	5.3	15.1	15.7	15.8
4+	2.0	10.1	8.2	8.3

* Children under 18

** Children of any age living with parents

*** Children under 16



Source: For Poland: Computed from Bogacka, H. (1976), Table 1, p. 4; Smoliński, Z. (1979), p. 15.
For Eng/Wales: Leete, R. (1979), Table 43, p. 97.

Since there are no special benefits for one-parent families in Britain either except for the nominal child benefit premium (9), such families rely heavily on the mass Supplementary Benefit System. In December 1981, there were 392,000 lone parents with 666,000 children on Supplementary Benefit, one-parent families making up 49.6 per cent of families with children in receipt of benefit (NCOPF, reprinted in NCH, 1984). According to information presented in Parliament in 1980, only 6 per cent of one-parent families relied on maintenance as their sole source of support, while over 50 per cent of lone mothers were on SB (Land, 1983). Thus a significant percentage of such families also rely on the mother's earned income.

Official recognition of the special needs of one-parent families with respect to day care services has not translated well into practice. In March 1976 there were 30,000 children under 5 in full-time local authority day nurseries in Great Britain and 27,300 places in "registered premises". These totals together are "scarcely enough to to cater for a few years increases in the number of children of one-parent families, let alone provide a comprehensive service" (Simpson, 1980). Simpson has calculated that there are about 15,000 extra children aged under five from one-parent families each year, so that the <u>total</u> number of places in local authority and registered premises is fewer than 4 years' <u>increase</u> in under-fives with lone parents. The author concludes that the 20 per cent increase in day nursery places from 1971 to 1976 is a case of

> "running fast but not even standing still" (ibid.: 4). ".. Day care services ... are based on the assumption that only a tiny minority, consisting of extreme priority

> cases should be placed in day nurseries, despite lip service paid to the priority needs of one-parent families" (ibid.).

School meals have a potentially important role to play in the diet of those in poverty and in child health generally, as was recognised by British legislation early in the century. Although the 1980 Education Act generally reduced the effectiveness of the school meals service, the school meals system continues to play a smaller welfare role in Poland than in Britain. Part of the reason for this is the fact that Polish schools break up earlier in the day, with lunch being eaten in mid-afternoon when parents have also finished work. By any standards, however, provision is low. In primary schools, where provision is better than elsewhere, 45 per cent of pupils have a glass of milk, 15 per cent have a two or three-course meal and 8 per cent have a hot one-course meal (Rada d/s Rodziny, 1979b). Parents pay for the meals of about 80 per cent of pupils, parents' associations, voluntary associations and parents' workplaces pay in whole or in part for the meals of 11-12 per cent while about 8 per cent of meals are paid for directly out of state coffers (ibid.: 39-40). The TPD have commented in the following way on their difficulties in arranging free school meals for children in need. Problems arise not only

> "because not all schools have dining facilities (due to lack of space or staff), but mainly because the subsidy the schools receive from the Anti-Alcohol Fund is too small, and children from non-alcoholic families receive a subsidy from the Ministry of Education for soup only. If the parents' association is hard up and the number of children in need of school meals large, it can be a difficult matter to arrange"
>
> (Chmieleńska, 1979: 35).

Before the 1980 Education Act, about two thirds of schoolchildren took school meals in England (Graham, 1984). The Act effectively removed the controls which governed the price and standards of school meals, and increased restrictions on eligibility for free meals. As a result, prices of school meals rose and the proportion of children taking them fell to one half (ibid.). Children on Supplementary Benefit and Family Income Supplement remain eligible for free school meals; in 1981 11.9 per cent of all English schoolchildren received free school meals while 37.1 per cent paid (Bisset and Coussins, 1982). However, take-up of this means-tested benefit is by no means universal. In a study of a random sample of 16,000 families carried out in 1978-9, 40 per cent of the 20 per cent eligible for free school meals were not in fact receiving them, while 25 per cent of eligible families were paying for school meals (ibid.).

Means-tested benefits often fail for the same reasons in Poland and Britain: stigma is attached to them, the procedure involved in claiming them is complicated, and people are often unaware of their existence or of the fact that they might be eligible. While provision of such social assistance is scantier in Poland and decisions more arbitrary, in Britain the situation is compounded by the Government commonly taking away in tax what they have just given in benefits - a phenomenon now widely and officially referred to as the "poverty trap". The tax threshold in Britain is currently roughly half average earnings, and about 4/5 of those who claim Family Income Supplement also pay tax (CPAG, 1983).

Public Care

In cases where families have been judged to be permanently or temporarily unable to carry out the functions allotted to them, or where no family exists, the state assumes jurisdiction over and responsibility for the children concerned. DHSS figures for 1982 show that 93,200 children were in care in that year, that is 7.5 per thousand of estimated population under 18 (NCH, 1984). In Poland, a total of 173,038 juveniles under the age of 18 were under court supervision in 1980, i.e. parental rights had in their case been curtailed, suspended or removed, the numbers of such children having risen between 1975 and 1980 by almost exactly 50 per cent (Rocz. Stat. 1981: 613). This increase was the result of amendments in 1975 to the Family Code which extended the scope of coercive intervention and adjudication in family matters in the name of child welfare (10).

There are certain important differences of procedure involved in placing a child in public care in Poland and in England and Wales. As a rule, proceedings in Poland are initiated by the Family Court itself (11). Formally, there is universal responsibility for reporting, but particular responsibility lies with such agencies as "the militia, educational establishments, voluntary welfare workers (opiekunowie społeczni), and organisations and establishments whose task it is to look after children" (Bulenda, 1983: 136-7). According to research carried out by Strzembosz (1979), the court most frequently initiated proceedings as a result of referral from the militia (in 30.4 per cent of cases). In 22.4 per cent of cases, proceedings were initiated on

referral from the court itself (for example, in connection with an offence committed by the juvenile). Educational institutions were a source of referrals in 16.2 per cent of cases, schools themselves being responsible for 13.3 per cent. Other agencies, including the health service, voluntary organisations, magazine editorial boards and the public prosecutor's office were responsible for the remainder of referrals (13.7 per cent). In addition, in 17.3 per cent of cases proceedings were not initiated by the court, but were dealt with by the court on application from a family member.

In Britain, the situation is rather different. Under the terms of the 1969 Children and Young Person's Act, juvenile courts are able to make orders relating to the case of a child on application from a local authority, the police, or an authorised person, i.e. a member of the NSPCC. Although local authority social service departments have the greatest powers in this respect, it is not social workers who tend to make initial identifications of cases, since their task is "reactive rather than proactive" (Dingwall, Eckelaar and Murray, 1983). Social workers act on referrals, and these emanate largely from health service workers. Dingwall and his co-workers (op. cit.), in their study of three social services offices found that 53 per cent of the children under 5 referred during the first six months of 1979 were identified by health service workers. "All but a handful of these referrals, in fact, came from health visitors" (ibid.: 13). There is, in addition, a social distance between the courts and the rest of the agency system which has been noted for England and Wales (ibid.), but which is absent in Poland.

These distinct procedural patterns highlight two important and not unrelated points. In the first place, they indicate the difference in content and meaning of health visiting in England and Wales and its counterpart in Poland. Clearly, the element of "social policing" which the job has been ascertained to include in England and Wales is lacking in Poland. Secondly, the locus of social control at least in cases of the public care of children tends not to be the home in Poland, but rather the public domain. These are issues to which we shall return in the following chapter.

There is evidence in both Poland and Britain which points to the link between deprivation and public care. Holman, for example, points to the disproportionately large numbers of children coming into care in Britain from deprived geographical areas. He refers to research by Packman which showed that 60 per cent of long-term admissions into care come from one-parent families, while investigations of his own revealed that one third of private foster children were those of unmarried mothers and deserted spouses (Holman 1976). In Poland, the relationship emerges even more clearly. A study of 400 inmates of a Children's Home for the under 3s carried out in 1975-77 by Klimkiewicz revealed that in 50 per cent of cases the reason for admission had been "alcoholism, prostitution and other forms of family disorganisation", while 39 per cent had been admitted because of the "straitened circumstances" of the parents (Klimkiewicz, 1980). Ministry of Health and Social Welfare figures for 1978 show, moreover, that of the 6,752 children under three years of age in Children s Homes, 56.7 per cent came from one-parent families (40.2 per cent

coming from two-parent families) (ibid.).

Occupational Welfare

The system of occupational welfare which operates in Britain has not received its fair share of scrutiny as Rose (1981) has observed. Yet as a source of "concealed and long-term advantages" (Parkin, 1972: 25) which reinforce and extend the inequalities embodied both in the class system and the gender order, its significance has grown rapidly during recent years. At the same time there is no claim that British company welfare provisions have a redistributive function; on the contrary, the expansion of "perks" for top management in recent years was justified by the 1979 Royal Commission on the Distribution of Income and Wealth in terms of its role in maintaining allegedly eroded income differentials: such benefits were provided

> "to attract and retain staff, and have expanded considerably over the years of income policy to combat the narrowing of the margin of executive rewards caused by the tax structure and pay restraints"
>
> (Field, 1981: 137).

A study of employment conditions in British industry carried out in 1969 by Wedderburn and Craig revealed, among other things, that over 90 per cent of non-manual workers were covered by sickness schemes, although in 46 per cent of establishments there was no such scheme for manual workers. Over a quarter of all firms had no pension schemes for manual workers, although almost all had pension coverage

for white collar staff. The latter also enjoyed longer paid holidays than did manual workers in over 60 per cent of establishments (Parkin, op. cit: 25). In his 1967-9 study of poverty in the UK, Townsend (1979) also found earnings to be positively correlated with level of occupational welfare. Field has provided more recent evidence that the beneficiaries of this form of welfare are not only non-manual workers, but also male. According to his figures, 8.7 million of the 11.5 million workers covered by company pension arrangements were male employees, while a 1974 DHSS study showed sick pay schemes to be far more widespread in industries with a high concentration of male labour (Field, op. cit.: 141). The more detailed evidence provided by Martin and Roberts (1984) shows that women who are full-time and non-manual employees receive better benefits than women who are in part-time manual work. While 80 per cent of the full-time female employees in their study said they would receive sick pay, only 51 per cent of part-time employees gave the same response. Similarly, 53 per cent of full-time women workers belonged to a pension scheme, compared with only 9 per cent of part-time workers. In all, benefits from company cars to food are closely tied to one's position in the labour market - "the chance of gaining a free meal increases with status: 5 per cent of manual workers gain free meals compared with 20 per cent for top managers" (Field, op. cit.: 152).

Occupational welfare has a stronger tradition in Poland, and although it shares with the British system a professed concern for the welfare of the workforces of particular establishments, it differs from it in that it is significant form of <u>public welfare</u> with

a purported egalitarian dimension in that its declared goal is to meet the welfare needs of the working population. The system is dually conceived and funded accordingly. "Basic" welfare (działalność bytowa) comprises such aspects as housing, collective accommodation such as workers hostels, the industrial health service, schools (one option in secondary education is to attend a three-year technical school attached to an industrial enterprise which offers some "in-house" technical training), enterprise farms, etc. and receives its finance from the budget which an enterprise has at its disposal for its overall operation. "Social" welfare (działalność socjalna) on the other hand is concerned with such provisions as holidays and excursions, colony camps and holidays for the children of the workforce, child day care facilities, cultural attractions, sports facilities, garden allotments, assistance for newly-weds and pensioners, etc. In order to finance these activities, enterprises have been required by statute since 1974 to put aside an amount equal to 2 per cent of the total wage bill. The 1974 legislation had the effect of ensuring that a minimum amount of cash would be available in every establishment, but was unable to reduce the spending of richer enterprises which have consistently devoted more than this minimum to the provision of welfare facilities and services (Mikulski et al, 1978). Furthermore, in linking the welfare fund to the wage fund, the new rules in effect created a situation where enterprises employing large concentrations of low-paid labour also tend to have the smallest welfare funds. The net result is that welfare funds per employed person tend to vary widely from enterprise to enterprise. This emerged clearly in a study of 15 major Polish enterprises carried out in 1977 (Krupa, 1980).

The levels of the welfare fund in 13 of these enterprises are shown in Table 5.4.

TABLE 5.4: Level of welfare funds in 13 state enterprises* (Poland, 1977)

Enterprise	Welfare Fund (thousand zł.)	Welfare Fund as % of Wage Bill	Welfare Fund per employed person (zł.)
KWK Makoszowy, Zabrze	19,377	2.6	3,339
KWK Bobrek, Bytom	13,925	1.9	3,077
Fabryka Maszyn Odlewniczych, Kraków	4,305	4.5	4,720
Krakowskie Zakłady Armatur, Kraków	5,661	2.1	1,571
Zakłady Górniczo-Metalowe, Zębiec	3,682	2.0	1,393
Pomorska Odlewnia i Emalierna, Grudiądz	5,317	2.3	1,606
Koneckie Zakłady Odlewnicze, Końskie	3,532	2.0	1,360
Zakłady Radiowe "Unitra-Diora", Dzierżoniów	9,841	2.1	1,486
Zakłady Apar. Elektr. "Mera-Refa", Świebodzice	3,231	2.6	2,234
Fabryka Kosmetyków "Pollena-Lechia", Poznań	3,805	-	1,601
Fabryka Wyrobów Runowych "Runotex", Kalisz	9,878	2.5	2,831
Zakłady Przemysłu Dziewiarskiego "Polo", Kalisz	5,249	2.8	1,968
Biuro Studiów i Projektów Służby Zdrowia	1,691	3.3	2,182

* These enterprises represent the 5 main branches of the Polish economy and include 2 coalmines, 5 heavy industry establishments, 2 machine industry establishments, 3 light industry establishments and one non-industrial establishment.

Source: Krupa, K. (1978), Table 1, p. 34.

Furthermore, since women constitute an inordinate proportion of the low-paid - in this study, in the enterprise with the lowest average monthly wage (2,697 zł.) 77.5 per cent of the labour force were women, while in the enterprise with the highest wage (6,672 zł.) only 14.1 per cent of those employed were women - their low wage status is compounded by poorer access to occupational welfare benefits, as in Britain.

The significance of the occupational welfare system in Poland is considerable. In 1981, for example, 27 per cent of all housing was allocated through the workplace (Rocz. Stat. 1982: 381); 19.3 per cent of all medical consultations in urban areas were accounted for by the industrial health service (ibid.: 431); 25.1 per cent of all

children attending day nursery attended an enterprise crèche (ibid.: 436); 16.9 per cent of all children attending nursery school attended to a parent's place of work (ibid.: 415); and 59.5 per cent of all nights spent in state-run holiday establishments were arranged through workplaces (ibid.: 446).

There is recent evidence that there are also intra-enterprise factors which cause occupational welfare benefits to accrue to those who already have higher rewards in terms of income, thus contradicting and defeating the egalitarian purpose, as it is presented, of this kind of welfare. In the first place, enterprises are charged with the statutory duty to keep full records of employees material and family circumstances. This is not carried out in practice. The only information found to be collected in the 1977 study was the number of children in whose name child allowances were paid out to employees in a given enterprise, an incomplete source since child allowances may be paid out in the workplace of either the mother or the father. It is this lack of knowledge concerning family circumstances in the workplace which led the TPD to make the criticisms quoted above on page 149. Welfare benefits therefore tend to be administered on the basis of declared need, a criterion which allows enterprise directors to express the view that the needs of the workforce are satisfactorily met and that the criteria for the distribution of benefits takes preferred recipients such as those on a low income and large and one-parent families sufficiently into account (Krupa, 1978: 36). Contrary to this view are the figures which show that in these same enterprises the range of facilities offerred did not correspond in an obvious way with

the needs of the workforce; a high level of female employment was not necessarily accompanied by more child care facilities - one enterprise where 68.9 per cent of the workforce were women, among them lone mothers, had no crèche facilities whatsoever (Krupa, ibid.: 35). Further statistical data shown in Tables 5.5 - 5.8 illustrate how within each enterprise the lower-paid and those with large families participate less in all aspects of occupational welfare, the exception being the communal catering facilities which are used marginally more frequently by these groups.

TABLE 5.5: Persons not making use of occupational welfare facilities by income and size of family (%) (Poland, 1977).

Kind of facility	Total not using facilities	p.c. income		No. of children		
		Below 1,500 zł	Above 1,500 zł	1	2	3+
Summer colony holidays + camps	64.8	72.2	59.1	67.6	63.2	66.1
Holidays	64.0	75.4	59.1	57.4	63.2	67.5
Excursions	63.8	67.8	62.1	69.9	64.2	63.0
"Houses of Culture"	77.7	83.0	75.5	80.6	82.0	84.8
Sports facilities	80.0	85.6	77.6	81.7	83.7	82.5
Catering facilities	77.3	75.2	78.1	79.7	81.0	77.0

Source: Krupa, K. (1980), Table 29, p. 52.

TABLE 5.6: Forms of day care for children aged 0-2 years by income (Poland, 1977)

	All children aged 0-2 years	Crèche/day nursery				Home help	Family help	no data
		Total	enterprise creche	local day nursery	creche in another ent.			
Total number	321	65	16	22	27	27	212	17
Total per cent	100	20.3	5.0	6.9	8.4	8.4	66.0	5.3
p.c. income (%)								
below 1,500 zł	100	11.9	4.2	3.5	4.2	7.0	73.4	7.7
above 1,500 zł	100	27.0	5.6	9.6	11.8	9.6	60.0	3.4

Source: Krupa, K. (1980), Table 11, p. 28.

TABLE 5.7: Children going on colony camps and holidays in selected enterprises (Poland, 1977).

Enterprise Number	All children eligible	Percentage of children going on colony holiday/camp					
		Total	Income		No. of children in family		
			Below 1,500 zł	Above 1,500 zł	1	2	3+
Total in 15 enterprises	1,374	35.2	27.8	40.9	32.4	36.8	33.9
Enterprise 5	176	25.6	22.1	30.0	14.8	28.1	26.6
" 6	144	22.2	23.0	16.7	14.2	25.0	21.5
" 11	145	36.6	31.3	40.0	21.1	43.6	25.0
" 12	105	22.9	28.3	13.6	27.2	26.0	12.0
" 13	192	64.6	52.0	66.6	70.0	60.4	67.2

Source: Krupa, K. (1980), Table 13, p. 31.

TABLE 5.8: Forms of day care for nursery-school age children by income (Poland, 1977)

	All nursery school age children	State nursery schools				Private nursery school	Home help	Family help	No data
		Total	enterprise	local	other enterprise				
Total number	570	252	69	143	40	7	19	267	25
Total per cent	100	44.2	12.2	25.1	7.0	1.2	3.3	46.9	4.4
Income (%)									
Below 1,500 zł	100	38.6	10.7	21.5	6.4	0.9	0.9	54.9	4.7
Above 1,500 zł	100	48.2	13.2	27.5	7.5	1.5	5.1	41.0	4.2

Source: Krupa, K. (1980), Table 12, p. 29.

A separate study carried out by Pawlukowicz between the years 1972-75 confirm these findings. Using as a sample the entire workforce (3,832 persons as of 1.9.75) of the industrial enterprises in a single voivodeship, he found that while in 1972 those with monthly earnings of below 3,500 zł. represented 79.7 per cent of employees and 82.1 per cent of enterprise holidaymakers, by 1974 they represented 70.4 per cent of the workforce but only 40.3 per cent of holidaymakers (Pawlukowicz, 1980).

Apart from the fact of a basic lack of knowledge among enterprise management concerning needs which must be the basis of any policy which claims to meet those needs, authors have pointed to the fact that the regulations which stipulate to whom preference should be shown incorporate two potentially conflicting principles: one which has egalitarian aims and favours those with low incomes, difficult family circumstances etc, and one which accords priority to employees who are judged to have given "good service" to the enterprise. It is this latter principle which is open to arbitrary interpretation and which has been criticised as the way in which political loyalty is rewarded, an unobtrusive means of adding to the income of a select few. Referring to this source of inequality, Tymowski has noted that it is an area untouched by social research, yet without such an analysis no clear picture of social stratification in Poland can be drawn.

> "One thing is certain - the social consumption fund as it is distributed among these

> groups fulfils none of the functions it is supposed to; it has no egalitarian goal, nor does it aim to equalise consumption or give preference to special need. Its aim rather is to administer privileges by way of particular material benefits and services to particular groups of workers and their families, such benefits being tantamount to an increase in their real incomes. This is therefore a kind of bonus, and one which is often very significant in financial terms"
>
> (Tymowski, 1977: 25).

In this connection, Kaser (1976) has described the grades of health care provision for which the government élite and their dependents are eligible at the Ministry of Health hospital in Warsaw. A new hospital for government officials has recently been constructed in Anin. According to the KOR document on the state of the Polish hospital system, the architects of the Anin hospital estimated the cost of each bed to be 13 million złoty, as compared with the construction cost per bed in an "ordinary" hospital of about 1.2 million (KOR, translated and introduced by Millard, 1982).

The under-representation of the more needy among those receiving occupational welfare benefits is not likely to result from outright discrimination. Few applicants in Krupa's study were actually turned down. More important was, for example, the fact that often the information concerning the availability of an attractive option did not reach people until it had been booked out, and even then it travelled via informal channels. Those most in need tended to make fewer claims, and justified their "passivity" more frequently by a conviction that their application would be unsuccessful and that there existed a

privileged group in the enterprise administration who "cornered" most of what was available. Costs were frequently prohibitive to those with low incomes and with large families, for the benefits offered by workplaces are subsidised facilities and services which have different consts relative to per capita family income, as is shown in the case of holidays in Table 5.9.

TABLE 5.9: Cost of holidays arranged through place of employment by income and size of family (Poland, 1977).

	Total cost	p.c. income		Number of children in family			
		Below 1,500 zł	Above 1,500 zł	0	1	2	3+
Inclusive cost in złoty per employee	1,348.6	1,449.0	1,326.0	720.0	1,344.0	1,637.0	1,700.0
Inclusive cost as % of p.c. monthly income	60.6	119.0	53.3	27.5	58.2	81.9	91.1

Source: Krupa, K. (1980), Table 32, p. 54.

Just over 17 per cent of workers with large families, for example, said that they did not send their children on colony holidays organised by the enterprise because they could not afford the expense involved, while only 2.1 per cent of one-children families gave this as a reason for not sending their child on such a holiday (Krupa, 1980: 44).

Maternity and Child Care Benefits

Maternity Leave and Benefit (12)

Maternity provisions are relatively comprehensive and generous in Poland and this pre-dates state socialism in that country. One of the first major pieces of social policy legislation following the creation of independent Poland in 1918 dealt with compulsory insurance in case of sickness and provided for medical and obstetric care before, during and after confinement, a cash benefit equal to 100 per cent of the worker's salary for a period of up to eight weeks, six of which were to follow birth. Often, however, it was the financial state of the insuring agencies which decided whether or not women received the full 100 per cent benefit during maternity leave. Post-war reforms rectified this situation. Legislation early in 1946 provided a guarantee for the unconditionality of full income maintenance during maternity leave, while leave itself was extended in 1948 from eight to twelve weeks (Piekut-Brodska, 1980: 4).

Since 1972, maternity benefit has been paid for 16 weeks for the first birth, 18 weeks for every consecutive birth and for 26 weeks in the case of a multiple birth. A measure of discretion is allowed in how this time should be distributed, but it is expected that at least two weeks will be taken before the birth, and at least 12, 14 or 22 weeks, depending on the nature of the birth, afterwards.

Maternity leave and benefit rights are automatically and unconditionally available to women by virtue of the fact of employment, regardless of the length of that employment. Entitlement extends

beyond natural motherhood to women who have have adopted infants under the age of four months (a maximum of 14 weeks until the infant is four months old), or under one year, when up to four weeks' leave with benefit may be taken. Where the mother has died during, or shortly after childbirth, the father retains maternity rights until the infant is four months old, or six months old in the case of a multiple birth. In cases of wrongful dismissal during pregnancy, entitlement to benefit is retained, and where the place of employment is closed down during pregnancy, a woman is entitled, not only to that part of maternity benefit payable after birth, but also to a benefit equal to maternity benefit (if alternative employment has not been found for her) from the date employment ceases until birth, which may be a period of several months' duration. Maternity benefit may be claimed up to six months after the last date on which it was payable, but is normally paid out by the employing establishment in the same way as salary, except in the case of those employed outside the state sector who are paid through ZUS, the State Insurance Agency.

The maternity rights of working women in Britain in contrast to those in Poland are conditional, involve a highly complex procedure if they are to be claimed, are extremely limited and ultimately rest on a lengthy appeal procedure if they are to be enforced. Part of the reason for this is the autonomy of private employers who occupy a structural position halfway between the women for whom provision is made, and the government which formulates policy. While some employers operate a maternity scheme at their own discretion, elsewhere conflict between women's and employers' interests has led to employer

opposition to the state maternity scheme. It has been noted, for example, that employer interest groups consistently criticised the maternity provisions brought in by the 1975 Employment Protection Act. "The claim has been made that maternity rights represent a further obstacle to the expansion of small firms at a time when such firms are potentially the main growth point of the economy" (Daniel, 1980: 2). The Employment Act 1980 which followed the 1978 Employment Protection (consolidation) Act and introduced new rights and amendments to existing rights is in Daniel's opinion to be viewed as a response to the argument concerning small firms. As they stand, the basic maternity rights accorded to working women on the grounds of natural motherhood are as follows:-

(a) dismissal purely or mainly on the grounds of pregnancy is unfair;

(b) a woman has the right to be re-instated in her job, or a similar job for up to 29 weeks after the birth of her baby. Women who are employed in workplaces with five or fewer employees do not have this right;

(c) a woman has the right to 6 weeks' maternity pay (as of April 1977), and

(d) a pregnant woman has the right to time off work without loss of pay to receive ante-natal care (as of October, 1980).

(a) Unfair Dismissal (13)

If a woman has been employed for at least 12 months (prior to to the 1980 legislation the requirement was 6 months), or 24 months if 20 or fewer people are employed, dismissal because of pregnancy

is unfair, but fair if the woman is no longer capable of "adequately doing the work" (Coussins, 1980: 6). In cases where a woman considers herself to have been unfairly dismissed, it is up to her to appeal the case within three months of dismissal, if necessary in an industrial tribunal. However, the Employment Act 1980 has made it harder for a woman to win her case since in the first place the employer may now justify his/her action in terms of the size and administrative resources of his/her undertaking. Secondly, before 1980 the burden of proof was on the employer and is now technically neutral.

(b) Reinstatement

Where a firm employs more than five persons, there is a right of reinstatement up to 29 weeks following birth. This is conditional on 1) having worked continuously for the same employer for at least two years counted from the beginning of the 11th week before the baby is due; 2) working until the beginning of the 11th week before the baby is due; 3) informing the employer in writing at least 21 days before leaving work of the intention to go on maternity leave and to exercise the right of return, giving the date the baby is due; 4) the employer has the right to write at any time after 49 days after the beginning of the week in which he/she was informed the baby was due, to request written confirmation of a woman's intention to return to work. If the woman does not reply to the employer in writing within 14 days, the right to return is lost; 5) the woman must write to her employer again at least 21 days in advance to inform him/her of her date of return. Although this is supposedly a right to reinstatement, in fact, following the 1980 Act, a woman no longer has a guarantee of

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of getting the same job back on return to work. Before the change in the law, a woman was entitled to a job as specified in her contract (except where her previous job had been made redundant, when a "suitable alternative" had to be offered). From 1980, the employer may claim for "any other reason that is not reasonably practicable for (a woman) to have (her) original job back" (Coussins, op. cit.: 12). "Unreasonable" refusal of an offer of a job "not substantially less favourable" leads to loss of right to reinstatement. The period spent on maternity leave breaks employment continuity for purposes of seriously, access to pension schemes, promotion prospects, etc, but not with respect to statutory rights such as redundancy pay.

(c) Maternity Pay/Maternity Allowance

Entitlement to maternity pay is based on the same service requirements as reinstatement. The amount paid is 90 per cent of basic pay, which comes out of the Maternity Pay Fund, less the state maternity allowance, regardless of whether or not a woman is eligible to claim this allowance. Again, if an employer refuses to pay, application must be made to the industrial tribunal. If the woman wins her case, but the employer still refuses to pay, the woman may make an application to the Secretary of State to consider her case. However, if he or she refuses to do this, the woman must make another appeal to the industrial tribunal. The law also stipulates that although a woman may ask her employer to pay her her maternity pay in a lump sum at the beginning of the six weeks, she has "no right to insist" (!) (Coussins, op. cit.: 14). Eligibility for the maternity allowance

depends on the level of National Insurance contributions, and from November 1984 is worth £27.25. Normally, maternity allowance is paid 11 weeks before birth and 7 weeks after birth for a minimum of 18 weeks. Mothers under 16 are eligible for neither maternity allowance nor Supplementary Benefit; they may, however, be able to receive assistance from their local authority which has discretionary powers in this regard.

(d) Ante-natal Care

This right, as all rights embodied in the 1980 Act, does not apply to part-time workers. Where an employer docks pay, the only recourse open to the woman is to lodge an appeal with the industrial tribunal.

With women occupying such a weak position under the grudging terms of the existing British legislation, particularly in the wake of the 1980 Employment Act, one might be forgiven for wondering whom the employment protection legislation is designed in this case to protect. The 2-year service rule for reinstatement and maternity pay in fact successfully excludes a large section of the female workforce from any protection whatsoever. Martin and Roberts (1984) found, for example, that 33 per cent of the full-time women workers in their survey would not qualify for employment protection rights under these terms. Some of these women are parents, as Coussins (op. cit.) has pointed out, who have had to break employment for lack of child care and play facilities during school holidays. The value of reinstatement rights depends, moreover, on the extent to which child care facilities are available to enable a woman to return to work within 29 weeks of

giving birth. In fact, Daniel's (op. cit.) study of new mothers and maternity leave showed that the right to reinstatement has had no general direct effect on the numbers of women who remain with their employers following the birth of their baby, women lacking the statutory requirements being as likely to return to the same employer as those who fulfilled them. Martin and Roberts' (op. cit.) study, which was carried out in 1980, showed that in all, 14 per cent of women had returned to work within 6 months of their first birth, while only 3 per cent returned within the same period following later births. The study also showed that return rates show some occupational variation (see Table 5.10).

TABLE 5.10: Proportion of women returning to work within 6 months of first birth by last occupation before first birth.

Last occupation before first birth	Proportion of women who returned to work within 6 months of first birth (%)	Base
Professional		17*
Teaching	22%	149
Nursing, medical + social	14%	210
Other intermediate non-manual	26%	80
Clerical	10%	1,259
Sales	10%	483
Skilled manual	20%	307
Semi-skilled factory	15%	917
Semi-skilled domestic	15%	183
Other semi-skilled	23%	175
Unskilled	19%	53
Did not work before first birth	6%	109
All women with children	14%	

Source: J. Martin & C. Roberts (1984), Table 9.12, p. 126.

* base too small to show %.

Women in "other intermediate non-manual" occupations were most likely to return to work within 6 months of the birth of their first child, while only 10 per cent of clerical and sales workers had returned within 6 months.

The Maternity Grant (Zasiłek Porodowy) and the One-off Birth Brant (Zasiłek Jednorazowy).

These are basically very similar benefits, both aimed at cushioning the immediate costs involved in the birth of a child. They differ in two respects. Firstly, the Maternity grant is the first truly universal benefit and is payable to all mothers on the birth of each child, while eligibility for the Birth Grant is based on employment status. Those eligible are employed women who have given birth to or adopted a child and are eligible for maternity benefit. Additionally, women who are the wives of men who are currently employed in the socialised sector, or who were formerly employed and at the time of birth were in receipt of sickness benefit, are also entitled to this benefit.

These two grants also differ in the fact that the Maternity Grant is a flat-rate benefit of 2,000 zł. for each still- and live-born child, while the Birth Grant is tied to income and number of children in the family. The level of the Birth Grant is arrived at by multiplying the child by a factor of 3, with a statutory minimum of 500 zł.

Together, then, these grants are usually worth approximately 2,500 zł. This in fact goes only a short way in covering the costs involved in equipping a household for a new baby. On the basis of normative requirements formulated by the Institute of Mother and Child (IMiDz) in Warsaw, the initial outlay for such necessities has been

costed at 7,246 zł. excluding a pram which is estimated to cost an extra 2,200 zł. (Graniewska, 1980: 65).

Under the National Insurance scheme, until 1982 mothers in Britain were eligible for a maternity grant of £25 depending on level of contributions. In 1982, this became a universal and automatic benefit for all mothers. However, the level of this benefit has remained unchanged since 1969, and in real terms is worth less than when it was introduced in 1911 (EOC, 1982).

Unpaid and Paid Child Care Leave.

The system of child care leave in Poland has been successively modified and extended since its introduction in 1968 (14). Initially unpaid child care leave was available for one year to employed mothers of children under two. There was from the outset guaranteed reinstatement, either in the same job or one equivalent from the point of view of pay and conditions. Employment was regarded as continuous for all purposes except pension rights. This was subsequently partially rectified in the 1972 amendment to the legislation, which also extended unpaid leave to a maximum of three years with respect to children under four, and provided that a maximum of 6 years' unpaid child care leave would be included in the calculation of pension rights. Further amendments came into force in 1976; leave could be split into no more than four parts - previously there had been no restriction in this regard. The same legislation also closed off the option for fathers to take unpaid child care leave which had been temporarily created by the 1972 legislation.

As a result of the 1980 Gdańsk Agreement, unpaid child care leave was supplanted in July 1981 by paid child care leave. Although, as in the Soviet Union, "childbirth ... (had) ceased to be a cause of income insecurity for women workers" (Minkoff and Turgeon, 1975-6:43), unpaid child care leave, if it had been an option chosen, had evidently left many families in pressing material circumstances in a society where the wage structure is geared towards two-income families, although as Trawińska (1981) notes, little if any research had been done in this area on which to base an assessment of the effects of social policy. The number of women availing themselves of unpaid child care leave had increased steadily from 23,500 in 1968 to 487,200 in 1980 (Piekut-Brodska, 1982), take-up varying among different categories of female workers. Two studies carried out in 1978 showed that the probability of take-up was greater the higher the husband's earnings, but lower the more the wife herself earned (Rada d/s Rodziny, 1979c). Take-up was also found to vary according to occupation, with doctors and teachers taking advantage of unpaid child care leave less frequently than any other occupational group, as is shown in Table 5.11 below.

On the basis of an analysis of personnel costs in State residential homes for children aged under three years, Graniewska has calculated that the social value of a mother's labour during unpaid child care leave was approximately 2,000 zł. per month (Graniewska, 1980: 56).

Eligibility for paid child care leave also extends beyond natural motherhood. A woman who has aldopted a child, or who stays at home to look after a child of her husband's is eligible, as indeed

TABLE 5.11: Take-up of Unpaid Child care Leave by Occupational Category (%)* (Poland)

Total	62.5
Engineers, economists	57.1
Doctors	41.8
Teachers	42.0
Other specialists	47.5
Technicians	61.5
Nursing related	59.6
Clerical workers	62.1
Skilled manual	68.9
Agricultural, Fishery and related	60.9
Shopworkers, catering & service industries	66.0
Unclassified	66.0
Unskilled manual	63.9
No data	77.0

* Based on a representative sample of 7,800 women whose maternity leave ended during 1977.

Source: Extracted from: Rada d/s Rodziny(1979c), Table 4.

is the child's father providing the mother gives her approval. Fathers are also eligible where the natural mother had died, is incapacitated through illness, or has had her parental rights removed or curtailed through the Family Court. In order to qualify for this benefit, it is necessary to have been employed for a minimum of six months, which may include any period of maternity leave which might have been taken. As in the case of the unpaid child care leave it replaces, it is available for a maximum of three years with respect to children under four years of age. Benefit rates are tied to per capita family income and are as follows:

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(a) 100 per cent of the minimum wage (3,200 zł. per month as of 1.09.82) where per capita income does not exceed 2,400 zł.

(b) 75 per cent of the minimum wage where per capita income exceeds 2,400 zł. but not 3,000 zł., and

(c) 50 per cent of the minimum wage, i.e. 1,600 zł., where where per capita income exceeds 3,000 but not 3,600 zł.

No benefit is paid where per capita income exceeds 3,600 zł. per month, while rates are doubled in the case of one-parent families.

Special Child Care Benefit (Zasiłek-Opiekuńczy)

There are two types of Special Child Care Benefit in Poland. The first was instituted in 1954 and was initially available under the same terms as sickness benefit. It provided a maximum of 30 days annual leave for a mother to look after a sick child under the age of 14, or a well child under the age of 8 during closures of day nurseries or nursery schools, during school holidays or in the case of illness of the family member usually responsible for looking after the child during the day. Until 1975, this was a more favourable benefit for non-manual workers, for whom sickness benefit represented 100 per cent of wages. Full income maintenance was extended to manual workers in the legislation of 1975 and the number of days of annual entitlement increased to 60. As in the case of unpaid child care leave, full rights to this benefit were extended to fathers at this time (who previously were eligible only if there was either no mother, or if she was incapaciated through illness), but withdrawn again in 1975.

Mothers have additionally been entitled since 1957 to two full days' annual paid absence from work if they have a child aged 14 or under. Until 1971 manual workers were not paid for this absence except in cases where wages had already been received in advance.

No equivalent of Poland's Special Child Care Benefit exists in Britain; if children are sick, parents must make their own arrangements for taking time off work. While aggregate sickness statistics published in the GHS suggest that women take time off for their children's sickness more often than men, Martin and Roberts' recent survey showed that altogether more husbands than wives were in the position of being able to take time off work without losing pay (Martin and Roberts, 1984). Thus, 44 per cent of husbands as opposed to 25 per cent of wives were able to take paid leave. Most wives (54 per cent) were not paid for time off, although in some cases time could be made up subsequently. Only a small proportion of parents (7 per cent of mothers and 6 per cent of fathers) were able to use their own sick leave in the case of an unwell child (ibid.).

Day Care for Pre-school Children

In any society which predicates its economic development on the mass employment of women mobilises its female workforce in an ideological context of female emancipation, and sets all this in a very general framework of social egalitarianism, the provision of socialised day care for young children must be a critical point of

policy. As was mentioned in the introduction to this chapter, a certain pattern of social development and social policy, in particular as this affected the employment of women, has been distinguishable over the 40 years of existence of the Polish People's Republic. We now examine the provision of day care for very young children within this context.

In pre-war Poland, day nursery places were few and far between: in 1939, 32 factory-run crèches accommodated 540 children (Graniewska, 1971: 21). A smaller number of day nurseries were also run by local government and religious and voluntary organisations. Immediate post-war expansion of day care as a response to the devastation of the nation's biological and material base meant that by 1947 there were 132 enterprise crèches and 114 day nurseries offering a total of 10,240 places (ibid.: 22) (15). Although the link between female employment and day care provision, shown in the preponderance of enterprise crèches, was clear from the outset (see Table 5.12), nevertheless increased provision at this time was not associated with the mobilisation of a female workforce - that was to come several years later with the six-year plan.

This plan, covering the years 1950 to 1955, was the first to reflect Soviet planning principles and saw the introduction of major social change. Part of this change, as we have seen, was the mobilisation of female labour, accompanied by the projection in the media of a model of the working woman served by a network of day nurseries. And indeed, the figures in Table 5.12 show that the increase in day nursery attendance in this period was never to be subsequently matched. While day nursery attendance more than doubled, the number of women

TABLE 5.12: Number of day care places by type of nursery (Poland, 1950-1981).

Type of nursery	Number of Places (thousands)							
	1950	1955	1960	1965	1970	1975	1980	1981
Local day nurseries	9.6	22.7	29.0	34.0	39.5	53.9	74.9	78.2
Enterprise crèches	13.8	25.9	22.5	23.8	25.5	28.2	28.6	28.0
Total	23.4	47.7	51.5	57.8	65.0	82.1	103.5	106.2
Seasonal day nurseries (rural)	3.7	7.9	0.2	1.0	0.7	0.2	-	-

Source: Compiled from Piekut-Brodska, D. (1980), Table 2, p. 15; Rocz. Stat. 1982, Table 17, p. 436.

employed in the socialised sector increased by 87 per cent (Kurzynowski, 1979); from 1955 onwards increases in female employment and day nursery provision have never been more than incremental.

As a result of the need in Britain for female labour during the second world war, the pattern of day care provision emerges as one of almost symmetrical contrast with that in Poland. During the war, local authorities in England and Wales set up day nurseries with exemplary speed, and in 1944 they catered for 70,000 children (Boss, 1973). This was a level which was not reached in Poland until after 1970. The demand for female labour dropped with the end of the war, however, and a joint Ministry of Health and Ministry of Education Circular of 1945 advocated the closure of full-day nurseries on the grounds that separating children from their mothers

> "was detrimental to the children's health and emotional development and that the right and proper policy would be to discourage mothers of very young children from going out to work, to provide part-day nursery schools or nursery

> classes for children between the ages of 3 and 5 and to regard full-day nurseries and their alternatives as supplements only to meet the needs of children whose mothers were bound to go to work or whose home circumstances were unsatisfactory"
>
> (ibid.: 372)

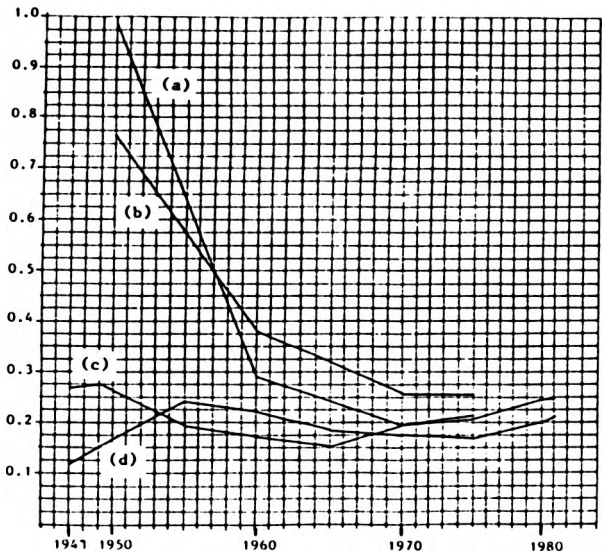
As a result of the relative effects of the acceleration of provision on the one hand, and deceleration on the other, Poland had approximately one third of the number of places available in England and Wales in 1948 but in 1957 had approximately twice as many (ibid.; Graniewska, 1971; Piekut-Brodska, 1980).

In both countries, provision and the accompanying ideological message were to some extent at odds with the reality of social and economic life. In Britain, policies which viewed women as dependents and at the same time saw their place as in the home, ignored the extent to which women wished or were obliged to participate in the labour market. In Poland, day care provision never really fully emerged to fulfil its advertised role in supporting working women. It is true that Polish writers, including Graniewska (1980), Kurzynowski (op. cit.), Piekut-Brodska (op. cit.), Haavio-Mannila and Sokołowska (1978) and others look back to the six-year plan as achieving most in terms of extending day-care for pre-school children, and in absolute terms there are grounds for this opinion, as has already been noted. The picture is quite different, however, when one considers day nursery

figures in relation to the number of married women employed in the socialised sector - rather than, as is more usual, with the number of employed women as a whole. This relationship is plotted in Figure 5.2 (16). When attendance is viewed against the linear increase in the number of employed married women, starting at a very low base in 1950 - Piotrowski (1963) has estimated a total of 308,000 such women in that year - it is clear that the failure in provision is a failure which dates from the beginning of the six-year plan. Paradoxically, the decade showing the greatest attendance increase in absolute terms (1950-1960), is also the most disastrous in terms of the service day care provides to working married women. The other side of this particular coin in Poland is the fact that provision in rural areas has always been negligible as has been noted in the previous chapter (17). The seasonal day nurseries which used to function during periods of intensive agricultural activity were cut with the collapse of the scheme to collectivise agriculture (Graniewska, op. cit.). This is reflected in the drop in the number of children attending such day nurseries between 1955 and 1960, visible in Table 5.12. The need for such provision remains acute, given the demands made in terms of time and energy of women in private agriculture.

In addition to the instrumental and ideological significance of the availability of pre-school day care for the emancipation of women, such provision also represents a substantial welfare benefit both by

FIGURE 5.2: Number of day nursery and nursery school places per number of women and married women employed in the socialised sector (Poland, 1947-1981)



(a) Numbeı of nursery school places per 10,000 married women employed in the socialised sector.

(b) Number of day nursery places per 10,000 married women employed in the socialised sector.

(c) Number of nursery school places per 10,000 women employed in the socialised sector.

(d) Number od day nursery places per 10,000 women employed in the socialised sector.

Source: Compiled from Kurzynowski (1979); Rocz. Stat. 1982

allowing a mother to contribute her earnings to the family income (18), and by virtue of the highly subsidised services it provides. Day nursery fees were until recently relatively low in Poland amounting to about 3 per cent of a monthly salary (Ziemska, 1978). Parental contributions covered 5.3 per cent of the real cost of a day nursery place in 1977 (Klimkiewicz, 1980), a cost which Graniewska (op. cit.) has estimated to have been 1,698 zł. per month in 1978. There is some evidence that given the present level of care in nurseries, the positive effects of nursery care are felt most among children from poor homes. Referring to this evidence, Pawelczyńska (1974:116) writes that

> "day care has a negative effect on the health and slows down the development of children living in relatively good material circumstances, while having a decidedly positive effect on children who start out in life in poor material circumstances and deprived of proper care."

It would seem to follow from the large socio-economic differences in the Polish post-neonatal mortality rate discussed in Chapter I, together with the social deprivation with which this is associated (see Chapter III), that there is a good case for integrating social and health policy as far as day care for very young children is concerned. There is in fact a precedent in this case for viewing day care as a form of primary prevention, in that after the second world war special day nurseries were established for children considered to be exposed to a risk of contracting tuberculosis (Krzysztofowicz, 1977).

Given the economic activity rates of married women in Poland and Britain, and the current levels of official provision of day care in each country, it is not surprising that demand in this area should

exceed supply. Table 5.13 shows that in Poland in 1980, 5.2 per cent of under-3s attended a state-run day nursery and 48 per cent of children between four and six years attended mursery school, with the final pre-school year being extended during the seventies to cover all six years olds.

TABLE 5.13: Percentage of pre-school children in day care by age (Poland, 1960-1981).

Age	1960	1970	1975	1980	1981
0-3 years (day nursery/crèche)	2.6	4.7	4.9	5.2	4.5
4-6 years (nursery school)	14.7	29.5	44.1	48.8	47.8
6 years	-	36.2	88.9	97.5	96.6

Source: Compiled from Rocz. Stat. 1978, Tables 17 & 35, p. 406, 379; Rocz. Stat. 1982, Tables 17 & 33, p. 436, 415.

Local authority provision in Britain is less than this, as may be seen from Table 5.14, and has been accompanied by a rise in the numbers of children being looked after by childminders, both registered and unregistered, and attending playgroups which are organised on a part-time and payable basis. Demand for greater provision of day care in Britain emerged in Bone's (1977) study. While 32 per cent of all children under 5 were found to use some form of day care, facilities were wanted by mothers for twice as many, although full-time care was desired for only a minority of children. In Poland, Graniewska (1980) has used the results of a 1978 GUS survey to establish that demand for day care places exceeds provision by a ratio of 3:1, an estimate which would appear to

TABLE 5.14: Provision of Day Care and Nursery School Places for the under-5s (Great Britain, 1977).

Type of Provision	Places per 100 under 5s
Local authority day nurseries	1.0
Private day nurseries	0.8
Registered childminders	2.76
Unregistered childminders	3.07-9.23 (est.)
Playgroups	12.6
Nursery schools/classes	35*

* 3-4 year age group

Source: CPRS, (1980), pp. 22-3.

exclude both peasant and peasant-worker families.

In a situation where demand outstrips supply, problems arise concerning the distribution of this scarce resource. In Britain, the discretionary nature of the powers of local authorities with respect to the provision of day care facilities has led to wide geographical variation in their availability. Moreover, although almost all local authorities operate under a system of priorities, when Margaret Bone applied her very strict criteria of need she found that on the whole "those within the need groups were slightly more likely than other children to be using educational provision and the comparatively rare day nurseries" (Bone, op. cit.: 55-56). In general, the use of day care was found to be associated with occupational class (see Table 5.15).

TABLE 5.15: Types of day provision used by children under 5 years, according to social class (Eng/Wales, 1974).

Type of day provision used:	All classes	I	II	III NM & IV NM	Total NM	III M	IV M & V	Total M
Playgroup	18	24	21	23	22	18	13	17
Nursery/primary school	9	10	14	5	10	9	8	8
Day nursery	2	1	2	2	2	2	1	2
Childminder	3	4	3	2	3	2	2	2
Crèche	1	1	1	-	1	-	-	-
No day care	68	60	60	68	63	71	76	72
Base: Children in social class (= 100 %)	2,501*	146	415	252	813	1,121	373	1,494

* includes 194 unclassified children.

Source: Bone, M. (1977), Table 2.7, p. 11.

Geographical disparities are also a characteristic of day care provision in Poland which is concentrated in urgan areas, as we have noted. The 1978 GUS study mentioned above showed, for example, that while 16.9 per cent of employed parents had not sent their children to a day nursery because there was none near their home, 35.1 per cent of peasant families and 47.1 per cent of worker-peasant families gave this as their reason (Wojciechowska, 1979). Secondly, while the 24-hour day nurseries which operate six days a week and serve families in difficult circumstances are being closed down, there is no evidence that ordinary day nurseries necessarily cater to those in greatest need (19). Ziemska (1978: 61), for example, writes that most day crèches

> "have children from cohesive, integrated two-generation families, with a fairly good financial and housing situation. Most of these parents have secondary or higher education and appropriate employment."

This should be placed against Miśko-Iwanek's (1981) finding that only one third of the eligible children of lone mothers attended day nursery (see p. 152). In Poland, where demand exceeds supply bureaucratic distributive mechanisms tend to break down. Łoś (1980: 70) has written, for example, that only

> "single parents or parents who both work can apply for places for their children, but even they have to be well-connected have strong union or Party support or be able to offer an adequate bribe to secure a place, especially if they want to use the centres near their residence or work place."

Day nurseries in Poland suffer from the ambivalence with which they are regarded by the authorities and by professionals alike. Still of symbolic and ideological importance, socialised day care for the under-3s was tacitly superseded in the 1970s by unpaid child care leave as the most favoured approach to child care; in 1973 the number of mothers on child care leave exceeded for the first time the number of children in day nurseries (Graniewska, 1980). For their part, psychologists and medical experts tend reluctantly to accept the unavoidable need for day nurseries, yet see a home upbringing, preferably by the child's mother, as being by its very nature the ideal solution:

> "(f)rom the social point of view crèches are an important form of assistance to families with a need for them. In the crèche, the child is provided with very good conditions of housing and hygiene and he is well-fed and under skilfull care. Nevertheless, this form of child care is not considered to be the best solution for helping the family to rear the child"
>
> (Ziemska, 1978: 70).

This comes close to the view expressed in Britain by those such as Pringle (1974) to the effect that day care outside the home must unavoidably be detrimental to a child's development, although in some cases it may be the lesser of two evils.

Studies into the effects of day care on young children were undertaken for the first time in Poland in 1959/60 under the auspices of the Institute of Mother and Child (20). A spate of these centrally-directed enquiries coincided with an official attempt in the 1960-65 plan, to discourage further increases in the employment of women; one instrument of this attempt, though an ineffective one, was a planned slow-down in the provision of day-nursery places (Graniewska, 1980).

Summaries of the earlier research have been provided by Bożkowa, Krzysztofowicz and Sztachelska (1971) and Ziemska (op. cit.), while Kopczyńska-Sikorska (1980) has recently given a more up-to-date account. Taken together, the findings constitute an internally inconsistent and inconclusive body of evidence, with later research generally providing more favourable conclusions concerning the effects on various aspects of development of day care. What is clear to emerge is the fact that the effect of day nursery care is critically dependent on a range of factors and there has been no evidence as yet which would suggest that such care per se, prejudices children's emotional, intellectual and physical development. In Britain, Tizard (1976) notes that there has been little systematic study of the effects of day care on children aged between 6 months to 2½ or 3 years, but that such "evidence as we have does not suggest adverse effects <u>if</u> the day care is of good qua-

lity" (p. 70). In her useful review of research on infant day care Silverstein (1981) notes that the effect of poor quality care (along with the many possible positive effects of day care) is not generally a well researched issue. Certainly these are not questions which have occupied Polish researchers.

Increased morbidity is, however, undoubtedly seen as the major problem of day care by Polish parents who otherwise would have used this facility or who have withdrawn their children from nursery for this reason (21). Diseases of the respiratory tract constitute 77.5 per cent of all morbidity in infants under one year of age and are twice as frequent as in the normal population (Kopczyńska-Sikorska, 1980).

> "The highest percentage of illness was found between the sixth and ninth month of life, which with an average entry age of 5 months indicates a higher rate of incidence during the period of acclimatisation.... 50 per cent of all illness occurring in the first 3 months of a child's attendance occur during the first month"
>
> (ibid.: 73).

The material base of the day care system and the quality of care it provides are clearly factors which must be looked at closely if this morbidity is to be kept within acceptable limits. In this connection, a 1977 study of a 37 per cent random sample of Polish day nurseries carried out by Wojdon-Machała and referred to by Kopczyńska-Sikorska (op. cit.) showed that 40 per cent had been constructed and functioned according to technical norms. The remainder, comprising buildings which had been converted for the purpose, had an outside area which was too small or non-existent, could not be adapted to meet daylight regulations,

had rooms which were too small and had no isolation rooms in case of infection. According to another author, day nurseries may be organised into groups of 40 or more children rather than the stipulated 20 (Klimkiewicz, 1980), a consequence of perennial staffing problems. In addition, day nurseries typically cater for 20 per cent more children than there are places (Rada d/s Rodziny, 1979d), although this situation was dramatically altered in the second half of 1981 when day nursery attendance fell by about 10 per cent as a result of the introduction of the system of paid child care leave.

Social Policy and the Family

Poland's "new wave" of social policy in the 1970s was presented in terms of "concern for the family", and was designed to afford a greater degree of accommodation between the mass employment of women and reproduction of the biological base than had been the case up till that point. Maternity leave was extended, and benefit levels raised for manual workers. There was a significant increase in the number of children aged six attending nursery school. However, the day nursery and crèche system, despite much debate on the subject, was not developed and the innovative unpaid child care leave which took its place, positioned the responsibility for and economic burden of the care of young children squarely in the lap of the family. For even if a mother did not avail herself of this "privilege", and not every mother could afford or wished to do so, child care was typically transferred to a grandmother or paid for privately at market rates.

This was not the only policy placing responsibility for child care with the family. The lack of a national minimum or a one-parent benefit means per se that it is "(the family) rather than the state's social security system (which is) the 'provider of the last resort'" as McAuley (1981: 7) has said of the Soviet Union. Certain administrative changes exhibit the same tendency. In 1975, amendments were introduced to the Family Code, the aim of which was to encourage adoption and fostering, and to make divorce more difficult where minors were involved (22). Between 1975 and 1978 the number of divorces granted, but not the number of divorce applications, fell by about 17 per cent (Niwińska, 1979). In addition, a major review was carried out during the seventies of children in residential care with a view to cutting institutional costs to the state (Bafia, 1979: 38). Of the 37,880 children and young persons in, or on a waiting list for, a residential home for children, 17.8 per cent or 7,590 were earmarked for release, 2,440 of whom were returned to a "corrected" family environment and the remainder placed in foster homes and schoolchildren's hostels, put up for adoption, etc. The annual savings to the state budget were estimated to be about 227 million złoty (ibid.).

Such policies, together with the characteristic shortages of commodities considered necessary and the importance of family and other informal ties in gaining access to such goods and services (see also Podgórecki's description of "squalid commonality" on page 88-9), confirm the economic meaning of the family. But the family in Poland also has political meaning - the two here cannot be divorced. The failure of state institutions to legitimise themselves and the

consequent retreat to the family have been observed by Podgórecki.

> "When political situations, professional careers, organisational arrangements and the climate of voluntary associations are unstable and do not provide even the minimum of psychological support, those belonging to such a dismembered society have a tendency to withdraw into the shell of the most elementary forms of human behaviour"
>
> (Podgórecki, 1984: 6).

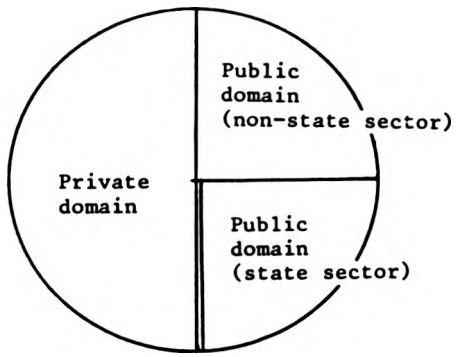
This would tie in well with Nowak's (1981) finding concerning the lack of identification with state institutions in Poland and the existence of a "social vacuum" between the level of primary groups and of the nation. What could be more different from Britain, where

> "most of us have been brought up ... to see 'our' governmental system, civil service, law courts, police force, and social security as acting for all of us, for the 'nation' seen as a unitary and unified whole"
>
> (Wilson, 1977: 12).

It would be wrong, however, to conclude that what has happened in Poland is simply a defensive retreat into the private domain where relationships are governed by ties of kinship and close friendship, and which is sealed off from a rejected public domain. Staniszkis (1979) has discussed the split in social consciousness between state and society, and this is also a recurrent theme in the reports of the Experience and Future discussion group (DiP, 1981). What these writers do not do, however, is to point out that this split represents a division within the public domain itself, according to whether relationships are governed primarily by state-bureaucratic principles and official roles, or by informal ties or the bureaucratic principles of non-state

institutions such as the various voluntary organisations (e.g. The TPD and the self-help groups which have formed under its aegis) and the Church. The view that there is "no public life" in Poland, expressed for example by Staniszkis (op. cit.) is contested here. In its place, a refined view of the major structural splits in Polish society is posited whereby what is commonly referred to as the "state", is more precisely the state sector of the public domain, while "society" refers to both the private domain, and the non-state sector of the public domain. This is represented schematically in Figure 5.3 below.

FIGURE 5.3: Sectors of Polish Society



The historical antecedents for these divisions in social reality are obviously of major importance. Podgórecki (1981) and Staniszkis (op. cit.) are two of those who have pointed to the effect of occupation under the Partitions in this regard. In addition, it seems likely that the traditional peasant way of life is another important source of influence, since Thomas and Znaniecki's (1958) description of peasant life bears considerable resemblance to the model proposed above.

> "The family is practically the only social group to which the peasant primarily belongs

> as an active member. Outside his family, his social milieu can be divided into two distinct and dissociated parts: (1) a political and social organisation in which he does not play an active role and in which he does not feel a member; and (2) a community of which he is an active member, but which is constituted by a certain number of groups whose internal unity is due merely to actual social intercourse and to an identity of attitudes. This dissociation is an essential feature of the original peasant social life."
>
> (Thomas and Znaniecki, 1958: 140).

The non-state sector accounts for interactions within the non-state institutions (i.e. those without a Party "cell") in the public domain, and the colonisation of bureaucratic structures by informal links, including those of "squalid commonality". Insofar as bureaucratic structures are able to act as host to this form of parasitic interaction, they gain a certain kind of legitimacy (Podgórecki, 1981). However, underlying all relationships outside the state sector of the public domain is the negative transcendentalism of the rejection of Party rule. This not only unites the non-state sector of the public domain and the private domain in opposition to the state sector, but also implies the potential for metamorphosis of relationships in these domains (cf. Sennett, 1977).

Given that what has been said concerning the structural configuration of Polish society has fundamentally to do with the nature of public and private domains and the way they interact, the argument has important implications for those health and welfare professions which offer expertise and exercise social control within the private domain. This primarily concerns social work, but applies also to health visiting

(pielęgniarstwo środowiskowe). Drawing as it does on its antecedents in the voluntary charitable organisations of the last century, social work of course had little chance of evolving into a profession in Poland, given the restrictions placed on all such organisations by the post-war regime. Although the first social work training course was instituted in 1966, by 1972 there was a total of only 197 trained social workers (Rosner, quoted in Łoś, 1980b: 78). A push to develop social work was part of the new policy package of the seventies and in 1974 and 1975 many more training courses were set up. By 1978 there were 3,000 trained social workers (Mikulski, 1978: 9). In effect, however, they now constitute yet another administrative category, and do not undertake home visits although this is part of their remit. To an extent this fate is shared by health visiting, as we shall see in the following chapter.

A greater degree of permeability of the boundary between private and public domains is evinced in the work of the Society of Children's Friends (TPD), partially funded by the state, but essentially a voluntary and non-state organisation. Having passed a resolution in 1967 to develop the social work aspect of its activities, the TPD by 1981 had 15,973 voluntary workers giving individual assistance under its auspices to 138,574 children - over twice the number of children assisted in 1980 (TPD, 1982b). A study of 845 voluntary workers carried out in Łódź in 1974 showed the majority to be women, more often than not non-manual workers, frequently employed in the educational sector, while 30 per cent were manual workers (Butrymowicz, 1975). The study also showed that workers spent about half their time organising extra-curricular

activities for children, 20 per cent on administrative activities in their local groups, and the remainder talking and giving advice to parents and liaising with other institutions (ibid: 335). TPD workers are able to give one-off benefits in cash or kind, and often mediate in the seeking of social assistance or advice on legal or health matters. They may also in extreme cases apply to the Family Court for removal or curtailment of parental rights, or to the procurator for the eviction, say, of a divorced husband if he is the cause of domestic problems. What is clear is that insofar as there is any crossing of the border between public and private domains, it is done by voluntary workers in the non-state sector, rather than by persons who are identifiably state employees.

If the private domain is not in Poland the location of state welfare activities, neither is it the locus for social control by the state. This is a feature of the public domain and is exercised through the labour discipline aspects of social policy and the Labour Code generally, in addition to the agencies for security, law enforcement and the administration of justice. This is a significant point of contrast with Britain where "the boundaries between the state and the family" (Land, 1979) are undermined not only by social workers, health visitors and applied psychologists, but also by the implicit family policies of the welfare state (ibid.). As Land has argued, a woman's marital status (and often her de facto marital status) may be a more crucial determinant of her eligibility and access to a variety of social services than whether or not she is a mother (ibid.). The logical consequence of this has been the subjection to covert surveillance of the most intimate

aspects of women's private lives as the basis for the administration, for example, of Supplementary Benefit or One-Parent Benefit. Clearly this calls at the very least for a questioning, not only of the ideology of "the privacy of the family" prevalent in Britain, but also of the totalitarian view of state socialism which argues that the private domain is sequestered by the state. What is seen as constituting outside interference in the family depends on how the family and relations within it are conceived. A belief that such interference should be minimal was in fact a critical factor influencing the early development of maternity and child health services in Britain, as Lewis (1980) has indicated. In practice this meant a historical reluctance to consider direct economic assistance as a way of meeting child health needs, with the implications this would have for the male's responsibility as provider and for the incentive to work, with attention being focused rather on educating mothers. It is this which in large part explains why in Britain today "the Welfare State means the State controlling the way in which the woman does her job in the home of servicing the worker and bringing up their children" (Wilson, 1977).

Notes

1. The description which follows is extracted from a fact-sheet published in Rada Narodowa Gospodarka Administracja (1978).

2. Arts. 128 and 129 of the Family Code state that "the duty of maintenance rests upon persons related to one another in a direct line of consanguinity .. Among collaterals, only brothers and sisters (irrespective of whether they are full or half blood) are liable to maintain one another... Descendants always have priority over ascendants, and the latter over brothers and sisters" (quoted in Lasok, 1968). In Britain, children's legal responsibilities with respect to maintenance of parents was abolished in 1948 (Land, 1983).

3. Jarosz (1979) states that 5.3 per cent of all convictions in 1973 resulted from convictions under Art. 186 of the Criminal Code for failure to pay maintenance.

4. However, hired labourers on private farms remain ineligible for child allowance.

5. As of November 1984, child benefit stands at £6.85 for each child.

6. Poland has, however, had no prerogative as far as contradictions between words and deeds are concerned. The British Budget of 1980 was presented by the Social Services Secretary as "the family Budget". The tax changes it brought involved an average annual loss of £36.90 per family. For families with children, there was an additional annual tax loss of £36.60 for each child. Nevertheless, the Prime Minister still felt able to confirm that there was "no question of families with children falling behind" (Lister, 1980: 5).

7. Before the reform, rights to child allowance were recognised only after an employee had served three months in a given establishment. If an employee was rightfully dismissed without notice, or if s/he gave up

employment, s/he did not regain child allowance eligibility rights until having worked 6 calendar months with the new employer. Unexcused absence, even if for a single day, led to loss of child allowance for that month (Balcerzak-Paradowska, 1980).

8. Analysing the results of a questionnaire administered to a 10 per cent sample of couples granted divorce decrees in 1973, Bogacka (1976) found that in 1974 although a single child received an alimony payment of on average 700 zł. per month, this amount dropped very steeply with increasing size of family. Thus, with two children in the family, average payment worked out at about 530 zł. each per month; with three children the average amount was 390 zł. and with four, 230 zł. per month. Alimony payments decrease less steeply in England and Wales. The Finer Report (HMSO, 1974) includes results of a Bedford College Legal Research Unit study carried out in 1971 which showed that alimony payments average £1.40 per week for a single child, decreasing to £1.00 per child where there are three or more children. In many cases, supplementary Benefits "iron out" these differences, since the amount of Supplementary Benefit paid out is net of sums received as maintenance.

9. This premium, referred to as the one-parent benefit is worth £4.25 per week as of November 1984, is payable regardless of the number of children in the family. If Supplementary Benefit is claimed, it will be reduced both by the amount of child benefit and one-parent benefit received.

10. Article 109 of the 1975 Family Code extends the grounds for the withdrawal of parental authority by the courts where the welfare of the child is at risk "even where the misuse of parental authority is not the cause" (Bafia, 1976: 4).

11. The Family Court replaced the Polish juvenile court in 1978.

12. The legal sources for the discussion of maternity and child care privisions currently in force in Poland are as follows:-

    (1) The Labour Code of 26.06.74 concerning sickness and maternity benefits (published in Dzienniki

Ustaw, 24, 5.07.74.

(2) Statute dated 17.12.74 concerning sickness and maternity benefits (published in Dzienniki Ustaw, 34, 1975) and accompanying rules for implementation.

(3) Instructions concerning sickness and maternity benefits introduced by Order No. 38 of the Chief of the State Insurance Agency (ZUS), published in Dzienniki Urzędowe, ZUS, 10-13, 1975.

(4) Order of the Council of Ministers dated 17.07.81, concerning paid child care leave, published in Dzienniki Ustaw, 19, 1981.

(5) Order of the Council of Ministers amending the Order concerning paid child care leave, published in Dzienniki Ustaw, 5, 1982.

(6) Resolution No. 46 of the Council of Ministers dated 7.04.78 concerning the one-off birth benefit published in Monitor Polski, 15, 1978.

13. The description of maternity rights in Britain is based on Coussins (1980).

14. Monitor Polski, 1968, 24, position 254.

15. Graniewska (1971) highlights the impetus towards the expansion of day care by quoting material presented at the first post-war Trades Union Congress which showed that while factory owners in Łódż had built only two crèches during the first six years following legal requirements introduced in 1924 to the effect that each factory employing more than 100 women should provide a crèche, between the end of the second world war and the end of 1945, 10 new day nurseries and 11 nursery schools had been constructed in the city.

16. Ideally, one would wish to compare day care places with the number of children of employed women over the post-war period. Were such data available, the slope of the graph in Figure 5.2 would probably

be slightly less steep, due to the drop in fertility over the period in question.

17. With the exception of state farms where crèches are provided and administered by the Ministry of Agriculture.

18. Family incomes where children attend day nursery are invariably higher than where they do not. See, for example, Table 5.8.

19. In 1981 there were 55 24-hour day nurseries in Poland, serving 3,500 children (Rocz. Stat. 1982).

20. For accounts in English of these early studies, see Ziemska (1978: 71-76) and Górnicki (1964). Heitlinger (1979: ch. 16) describes a similar chronology of events and accompanying debate in Czechoslovakia.

21. The turnover of attendance in day nurseries in Poland is high, with the annual number of children registered being consistently almost double the number registered on any given day.

22. Two main trends are observable in the 1975 amendments to the 1964 Family Code. One is the extension of state power, through the court, with respect to the family. The other is the extension of familial or quasi-familial solutions. For example, Arts. 118, 124, 125, 146 and 149(4) are designed to encourage adoption and fostering, while Art. 58 is designed to make divorce between couples with small children less easy.

CHAPTER VI

THE CHILD HEALTH SERVICES

Introduction

Both Poland and Britain operate centrally financed and directed health care systems. The position occupied by children's health services within these systems, however, varies greatly. The priority accorded to child health in the Polish national service is reflected in the way in which child health care facilities form an integral yet organisationally distinct entity at each level of provision from the local przychodnia rejonowa or neighbourhood polyclinic to the National Institute of Mother and Child. At each hierarchical level, prevention and cure are conceptually and organisationally fused in a hospital-centred health care system. The picture is somewhat different in Britain, where national planning for children has been described as weak (HMSO, 1976). Moreover, despite integration of the health services in 1974, prevention and cure remain largely separate aspects of the health care of British children. Much of the former type of work is still carried out in child health clinics by clinical medical officers although their autonomous existence and the vestiges of the welfare and educational models of child health care they embody, have been challenged on the one side by the paediatricians who have formulated the notion of a community paediatrics, practised in the community yet hospital-based, and on the other by the GPs, most recently in a report on child health and prevention published by the Royal College of General Practitioners (RCGP, 1982).

In this chapter we shall be concerned to trace some of the main lines of development of hospital-centred child health care in Poland, drawing comparisons where relevant with Britain, and paying special attention to the relationship between prevention and cure. This is followed by a consideration of how the availability of health care facilities matches health needs. The chapter ends with a more general analysis of the nature of family-state interaction, for this emerges as an important factor in determining how child health care is divided. First of all however, and in order to place the ensuing arguments in their administrative context, the chapter begins by presenting a description of the main organisational characteristics of the Polish health service in general and the maternity and child health service in particular - knowledge of the administrative structure of the British NHS has been assumed.

The Polish Health Service - General Background (1)

Although the post-war Polish Ministry of Health had been set up in April 1945, at that time health care remained in the hands of various institutions such as the Ministry of Labour and Social Welfare, the Ministry for Industry and the Ministry of Education, with hospitals in the hands of the State Insurance Agency, the Red Cross and other religious and private bodies. Not until the first three-year plan (1947/9) was a model for a comprehensive state health service developed, culminating in legislation in 1948 (2) which provided the foundations for a state health service based on a planned economy. Soon afterwards, in 1951,

industrial and insurance health care programmes were brought within the jurisdiction of the Ministry of Health, and in the same year the production and distribution of pharmaceuticals were nationalised. The year 1952 saw the responsibility for the school health services transferred from the Ministry of Education to the Ministry of Health, as were the University departments of medicine, pharmacy and dentistry, becoming reconstituted as medical academies in the process. In the following year all hospitals were incorporated into the Ministry of Health, as was the state Sanitary Inspection Service in 1954.

Concurrent with this accelerated process of integration was the establishment of other main features which have distinguished the Polish (and Soviet) Health Service throughout the post-war period. A hierarchical, hospital-based and territorially organised system with strong horizontal links with local government was to emerge.

Prior to the 1973-75 reorganisation of local government and the health service in Poland, each voivodeship - of which there were 17 - or voivodeship status city - of which there were 5 - was divided into health districts, referred to as "preventive-therapeutic" districts (obwody zapobiegawczo-lecznicze), which were in turn divided into a number of sub-districts or neighbourhoods known as "rejony" which represented the basic territorial unit for health care delivery. The health department (wydział zdrowia) in each voivodeship local authority bore overall responsibility for the health services provided by the health districts within its territory, while each health district was usually coterminous with the administrative territorial unit known as the powiat

or county, of which there were several in each voivodeship. At this level too, horizontal connections existed between local government and health service institutions. Otherwise, though, the system was characterised by strong lines of vertical subordination, but weak horizontal links between the various health care institutions both at the voivodeship and health district level.

There was an awareness of the drawbacks of this kind of organisational structure, and towards the end of the sixties an innovative form of organisation of health care delivery, the integrated health care complex or ZOZ (Zespół Opieki Zdrowotnej) was introduced in some areas on an experimental basis. The aim of the ZOZ was to integrate all aspects of health care, including inpatient and outpatient care, emergency services, social assistance functions and the sanitary inspections service within a given geographical and administrative unit. Within the new integrated complex the hospital occupied a central and dominant position.

The changes in the structure of local government which took place in Poland in the first half of the seventies involved the division of the country into 49 instead of the previous 22 voivodeships. The county or powiat was abolished, while in rural areas the administrative unit of the gmina or commune was introduced (3). From 1975 onwards, each of these 49 voivodeships has been divided into a number of ZOZy, creating a total of 412 such integrated health care complexes nationwide. The area each covers corresponds to the obwód which it replaces and therefore also to the former powiat, a catchment area which may contain

anything from 30,000 to 250,000 inhabitants.

The overall organisational structure of the Polish health service may be viewed as having 3 or 4 levels, depending on whether or not one disaggregates a central and regional or inter-voivodeship level at the apex. The structure is represented in Figure 6.1, which is an adapted version of the schema put forward by Indulski and Włodarczyk (1978).

At a central level the Minister of Health is expected to liaise with other Ministers in matters relating to health. In practice, communication is weak. The Ministry of Health has 14 main departments, through which it performs its functions which have been listed as the following:

a) the studying of health needs and ways of meeting them,

b) the establishment of principles of organisation and operation of health facilities and programmes,

c) the maintenance of relationships with professional and voluntary organisations concerned with health,

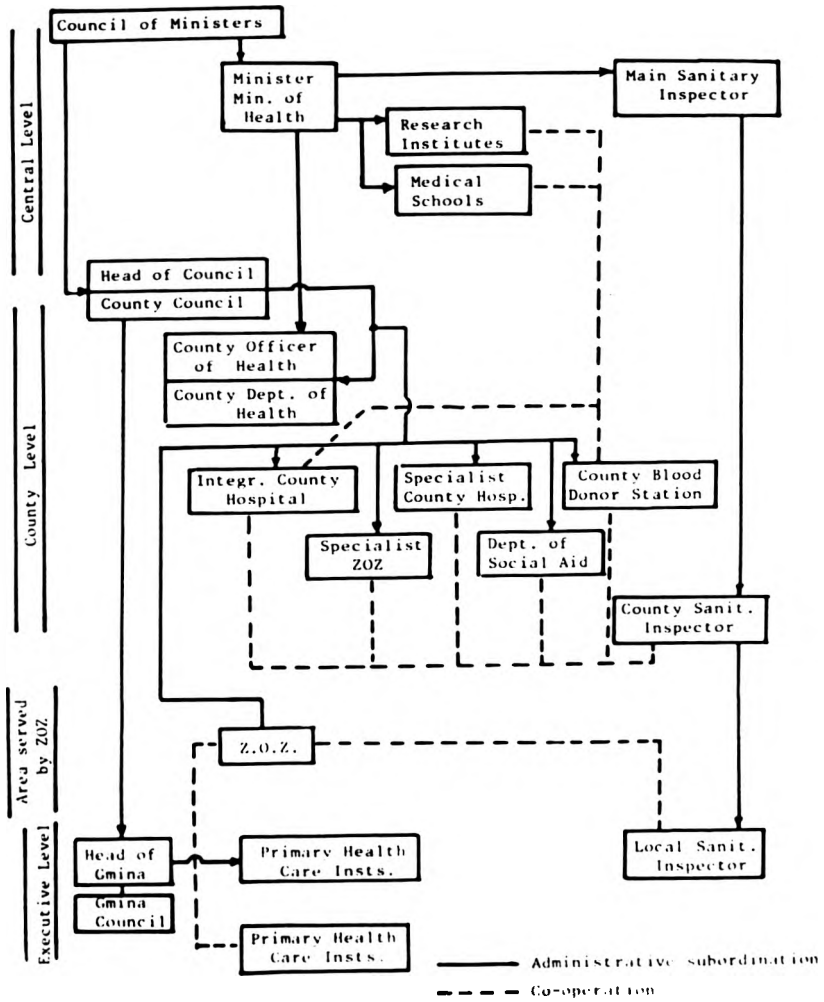
d) the formulation of plans for the future development of the health services, and

e) the supervision of the technical or professional aspects of the programmes in each sector of the health field, as it is implemented on the voivodeship level.

(Roemer and Roemer, 1977)

The detailed information and advice on which the Ministry bases its policy-formation and planning is provided in the main by the National Research Institutes, of which there are fourteen (4). Where appropriate, the Institutes also provide specialist ambulatory and inpatient care.

FIGURE 6.1: Organisational levels and links with state administration in the Polish health service.



Source: Indulski, J. and Włodarczyk, C. (1978), p. 413.

On a regional or inter-voivodeship level, there are the ten Medical Academies, which offer specialist ambulatory and inpatient care in the teaching hospitals (known as szpitale kliniczne) attached to them.

A range of health care facilities exist at the voivodeship level, and come within the jurisdiction of the local authority department of health. Each voivodeship has an integrated voivodeship hospital (wojewódzki szpital zespolony) which offers specialist inpatient and outpatient care within a given voivodeship (5), receives referrals from the ZOZy in that voivodeship and exercises technical control over services rendered within those ZOZy. The voivodeship may also contain a specialist ZOZ (Specjalistyczny Zespół Opieki Zdrowotnej) which offers specialist inpatient and outpatient care within a specialty, or to particular population subgroups, such as those employed by or attending institutions of higher education (an academic ZOZ), those working in industry (an industrial ZOZ), or mothers and children (a MCH-ZOZ).

Some voivodeships also have certain non-integrated health facilities. By definition these facilities are more weakly related to the ZOZy in any given voivodeship, since they provide highly specialised services to a catchment area which extends over more than one voivodeship. Such non-integrated institutions include specialist hospitals and sanatoria (jednoimienne szpitale (sanatoria) specjalistyczne), blood donation and sanitary inspection (sanepid) centres.

At the peripheral level, the integrated health care complex or ZOZ, as has been mentioned, serves a catchment area of 30,000 to 150,000

people (6). Towns with over 150,000 inhabitants may be split into more than one catchment area, each with its own ZOZ. The ZOZ is a separate organisational and budgetary unit and as such is financed directly from the voivodeship budget and administratively responsible to the voivodeship department of health and social welfare. Hospital care within the ZOZ is provided by the ZOZ general hospital in the fields of paediatrics, gynaecology/obstetrics, surgery and internal medicine, while specialist outpatient care is provided to the inhabitants of both town and country by a specialist polyclinic (przychodnia specjalistyczna) which may or may not be attached to the ZOZ hospital. Emergency services are provided by the dział pomocy doraźnej which retains some autonomy within the integrated ZOZ framework. Some services, for example laboratory facilities, have been integrated more successfully than others, while yet other services, such as laundry, transport and catering, remain unintegrated.

Primary care is organised somewhat differently in urban and rural areas. In towns, the neighbourhood polyclinic (przychodnia rejonowa) serves the inhabitants of one or more of the basic urban catchment areas (rejony), each of which may number from 3,000 to 5,000. The primary care team includes specialists in internal medicine, paediatrics, obstetrics and gynaecology and dentistry. The primary care unit in rural areas is the rural health centre (Wiejski Ośrodek Zdrowotny or WOZ), usually employing a dentist and a practitioner qualified in internal medicine and with some training in paediatrics and obstetrics and gynaecology, while the basic catchment area tends to be slightly larger, varying from 3,000 to 6,000 inhabitants. The more outlying regions may

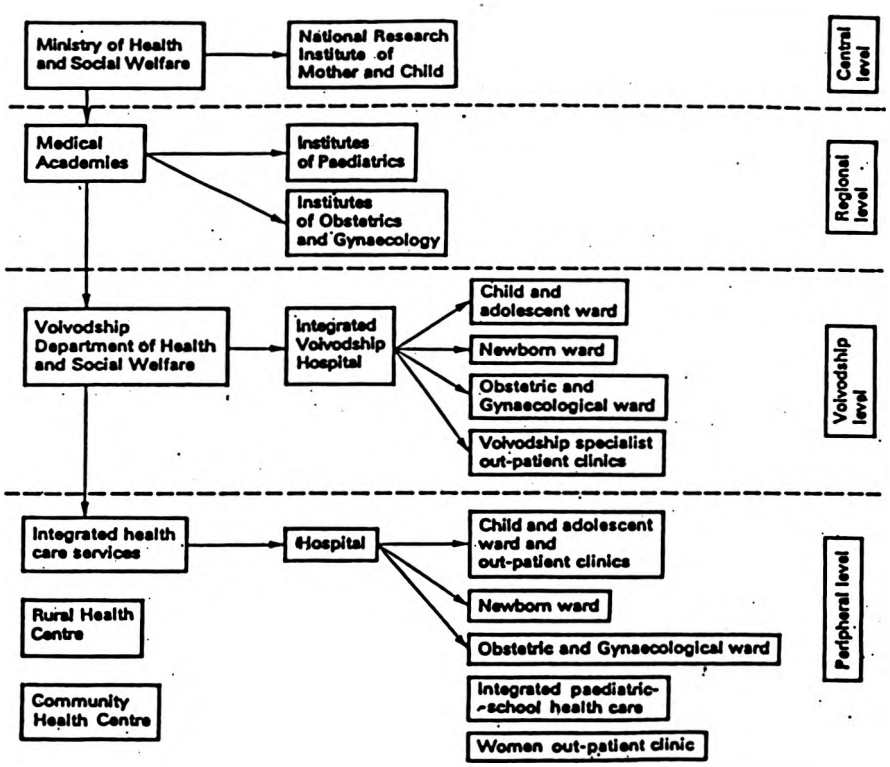
be served by WOZ outposts. These health points (punkty zdrowia) may be staffed by a feldsher or nurse. However, for some time their number has been diminishing. On the other hand, in those larger rural centres which serve as the base for the gmina local authority, the rural health centre (WOZ) become known as the Gmina health centre or Community health centre (Gminny Ośrodek Zdrowia or GOZ). Theoretically, the health team in these centres is the same as in the urban neighbourhood polyclinic, although GOZ facilities may also include a birthing room (izba porodowa).

Beyond these services, the ZOZ is responsible under the Department of Social Services created in 1975, for the provision of day and residential care for children under three, and also for homes and day-care centres for the elderly. The ZOZ may also encompass within its ambit industrial and academic polyclinics where no specialist polyclinics exist in these fields.

The Maternity and Child Health Service

The maternity and child health services in Poland are linked, and while forming an integral part of general health services at each level, nevertheless together constitute a separate subsystem with its own hierarchical organisation of health care and technical control from neighbourhood to national level. This is illustrated by the schema in Figure 6.2.

FIGURE 6.2: Organisational levels of the Polish maternity and child health services.



Source: IMiDz (1980b), p. 52.

At a central level, the National Research Institute of Mother and Child (Instytut Matki i Dziecka or IMiDz) is the main institution by means of which academic medicine and the medical profession influences policy formation and planning in maternity and child health. The institute has many varied functions which have been listed as follows.

1. It plans, organises and carries out research in biological, clinical and social fields;
2. it co-ordinates research in these areas which is carried out by other bodies subordinate to the Ministry of Health and Social Welfare (e.g. the Medical Academies), in accordance with terms laid down by the Minister;
3. it draws up proposed plans for the functioning of the health service in matters to do with maternity, reproduction and the health care and development of children;
4. it exercises technical supervision at a national level (krajowy nadzór specjalistyczny) in these areas;
5. it keeps up-to-date with scientific advances both in Poland and abroad which are related to the Institute's activities, and also initiates such scientific work;
6. it participates and assists in the putting into practice of research findings. One of the ways it does this is to issue periodical instructions (wytyczne) to health care institutions;
7. it is involved in the further professional qualification and specialisation of its own and other employees;
8. it co-operates with the Polish Academy of Sciences, universities and scientific institutes, professional and scientific associations and makes contact with such bodies abroad, and
9. it prepares and presents scientific and statistical information and publishes its own findings.

(Krzysztofowicz, 1977).

In addition, the Institute provides extensive impatient and outpatient facilities in Warsaw, together with impatient care for children with pulmonary complaints at its branch in Rabka.

Again at a national level there is the specialist ZOZ, the Child Health Centre (Centrum Zdrowia Dziecka) at Międzylesie near Warsaw. This is a "showcase" institution financed by voluntary contributions which offers highly specialised inpatient and outpatient care to a national and international clientele.

The regional level of the maternal and child health service in Poland has gained importance since the re-organisation of the health service in the mid-seventies. All facilities carrying out functions related to maternal and child health within each medical academy underwent integration at that time and Institutes of Gynaecology/Obstetrics and of Paediatrics were formed. Such institutes now exist as part of each of the ten medical academies in Poland. In addition to their role in undergraduate and specialist training and in research, the Institutes offer both inpatient and outpatient specialist care and participate in regional technical control (nadzór regionalny), supervising the specialist control exercised at voivodeship level (wojewódzki nadzór specjalistyczny).

At voivodeship level, the main organisational unit of the MCH services may be either a specialist MCH ZOZ (Specjalistyczny ZOZ nad Matką i Dzieckiem), or the MCH polyclinic which may or may not be attached to the integrated voivodeship hospital. The specialist MCH ZOZ

encompasses all the MCH facilities which exist on this level (hospital, specialist sanatoria, specialist outpatient clinics). In 1979 such specialist ZOZy operated in 12 voivodeships (7). The remaining voivodeships were served by voivodeship MCH polyclinics for outpatient care, inpatient care being provided by the appropriate wards in the integrated voivodeship hospital.

The voivodeship MCH polyclinic has three sections: reproductive medicine, child and school health and health service organisation - the latter being at times staffed by one person. The clinics and other facilities in each section may serve the needs of that section only, or those of the polyclinic as a whole. The tasks of the polyclinic are varied. In addition to providing specialist treatment on an individual basis, receiving referrals from the ZOZy within the voivodeship, and exercising specialist technical supervision of the health care provided within the voivodeship, the polyclinic

a) analyses epidemiological data and establishes health needs; it also develops ways of improving health care for children and pregnant women.

b) It draws up programmes for preventive, therapeutical and rehabilitative health services for these groups, and analyses and provides these services;

c) it cooperates with the voivodeship centre for post-graduate medical training and in the organisation and provision of such training;

d) it supervises and reports on the residential and day institutions for children under three in the voivodeship;

e) it liaises with the voivodeship career and educational advice centre, providing medical consultations where necessary, and

also cooperates with the appropriate educational institutions in organising health colony camps and holidays;

f) it cooperates with other health service institutions, the voivodeship education authority (kuratorium), and voluntary organisations.

At the level of the integrated health care complex or ZOZ, it is the chief of the children's ward in the ZOZ hospital who coordinates the provision of child health care (while the chief of the obstetric and gynaecological ward has similar responsibilities with respect to services in these fields). Apart from his/her tasks in conjunction with the everyday running of the ward and outpatient clinic, the paediatric ward chief exercises technical supervision over all the paediatric clinics in the neighbourhood polyclinics, together with the child health care administered in the rural health centres included in the ZOZ. The hierarchical organisation of technical accountability and control within the ZOZ and outside it is a clear statement of the hospital-centred nature of Polish health care, with hospitals and hospital physicians formally responsible for care further down the system. However, administratively, all ZOZ employees are responsible to the ZOZ director.

In order to satisfy the three fundamental principles of MCH care, or developmental age medicine (medycyna wieku rozwojowego) as it has been conceived in Poland - that is, the principles of continuity of care, integration of services and comprehensiveness of services, the following organisational pattern has been adopted as the basis of primary care.

In towns, as has already been described, the primary care centre or neighbourhood polyclinic (przychodnia rejonowa) serves one or more basic catchment areas known as neighbourhoods or rejony, and each of these areas may contain anything from 3,000 to 5,000 inhabitants. Within the neighbourhood clinic there is a separate clinic for women known as clinic K (poradnia K), which is largely concerned with reproductive medicine in its preventive and therapeutic aspects. (The other clinics which go to make up the neighbourhood polyclinic in urban areas are the clinics for sick and well children respectively, the clinic for general medicine and the clinic for dental care). According to the Ministry of Health and Social Welfare instructions which were issued in 1973 in connection with the setting up of the integrated health care complex system, each women's clinic should cater for 3-4 neighbourhoods or rejony, i.e. a general population which may vary from 10,000 to 20,000 people.

Primary care for children and adolescents - what is referred to in Figure 6.2 as "integrated paediatric-school health care", is carried out in the paediatric-school clinic for children up to 15 years of age, with an aim to extend the age range to 18 years. In fact, integration of local and school health services is being introduced gradually, and it was reported that in 1979 approximately 40 per cent of children in towns were receiving integrated care with an aim of full coverage by 1985 (Rada d/s Rodziny, 1979e). In 1982, approximately 25 per cent of ZOZy were without a school clinic (8). In rural areas, where health centres are staffed by a generalist doctor for each rejon, child health care has been "integrated" from the outset. Elsewhere, the paediatric-

school rejon covers an area equal to 1-2 general rejony or neighbourhoods, that is, it may cover an area populated by anything from 3,000-10,000 inhabitants. The current maximum number of children a paediatric-school rejon may serve is 1,500, but the aim is to reduce this to 1,000 by 1990 (9). This clinic, and in rural areas the health centre is the site of the national surveillance programme for infants and those pre-school children who do not attend day nursery or nursery school (the programme is shown in Table 6.1), and also provides primary care for sick children.

Arrangements whereby health care is provided for schoolchildren are very varied however. First of all, integrated services are as a matter of course administered in those rural health centres staffed by a single doctor, usually a generalist with a basic minimum training in obstetrics/gynaecology and paediatrics, or, increasingly rarely, a nurse or feldsher. So far, integration has been found to work best in these rural areas and in small towns. Secondly, where full integration has taken place, there is the urban paediatric-school rejon, where the clinic may be situated in the polyclinic or the primary school. Where integrated paediatric-school rejony exist, the work may be divided in two ways. Either one doctor will have under his/her care all or a proportion of the children aged 0 - 15 years, including nursery schools and schools (the Poznań variant), or one doctor may concentrate on the children aged between 0 and 7 years, including nursery schools, while a second is responsible for children aged between 7 and 15 years and schools (the Sopot variant). Elsewhere a doctor may be employed on an hourly or full-time basis, and again the clinic may be situated

TABLE 6.1: Child health surveillance schedule currently in force in Poland*

Age limits currently in force	Periodical medical examinations	Screening and Rescreening Tests																						Health Balance
		Apgar Scale	Phenylketonuria Test	Height	Body Weight	Chest & Head Circumference	C-S	Dental Age	Sexual Maturity	Psychomotor Develop.	Mental Development	Motor Efficiency	Hip Joint Socket	Balance	Hearing	Speech (Articulation, Rhythm)	Visual Acuity	Binocular Vision	Colour Vision	Tuberculin Test	Chest X-Ray	Blood Pressure	
1 week		S	S	S	S	S	S						S										First Balance (in newborn ward)
2 months	Examination in child's home																						
3 months	2 examinations in clinic				R	R																	
Second quarter	2 examinations in clinic				R	R				R			R										
Third quarter	Examination in clinic				R	R		S		R													
Fourth quarter	Examination in clinic			R	R			R		R													
2 years	Examination in day nursery			S	S			S		S					S			S		S			Health Balance
3 years	Examination in nursery school			R	R																		
5 yrs 8 m. - 6 yrs 7 m.	Examination in nursery school			S	S			S			S	S		S	S	S	S	S		S			Health Balance - Health certification of readiness for school
7 years	Examination in primary school			R	R										R		R						
8 years	Examination in primary school			R	R										R		R						
9 yrs 8 m. - 10 yrs 7 m.	Examination in primary school			S	S			S	S			S		S			S			S			Health Balance - Health certification for P.E. group
11 years	Examination in primary school			R	R																		
12 years	Examination in primary school			R	R				R								R						
13 yrs 8 m. - 14 yrs 8 m.	Examination in primary school			S	S			S	S		S	S		S	S	S	S		S	S			Health Balance - Health certification for further study/employment
15 years	Examination in secondary school			R	R																		
16 years	Examination in secondary school			R	R												R				S		
17 yrs 8 m. - 18 yrs 7 m.	Examination in secondary school			S	S				S			S		S			S			S	S	S	Health Balance - Health certification for employment/higher education

S - Screening during health balances;

R - Re-screening in intervals between health balances

* on basis of instruction 8/76, MZiOS, 26.06.76.

Source: Serejski, J. (1982), Table 1, pp. 20-21.

in the polyclinic or the primary school. Finally, in the case of secondary schools, i.e. where schoolchildren are aged between 15 and 18 years, a doctor is employed on an hourly or full-time basis to administer school health care in the secondary school.

The Social Context of the Development of Child Health Care

Health care as it is experienced both by professionals and lay persons cannot be understood in organisational or medical terms alone; reference must also be made to the social context of that care. Indeed, what are offerred as organisational facts or objective medical concepts must themselves be viewed in terms of the power of different groups (cf. Stacey, 1977). In Britain, as has already been mentioned, the autonomy and power of the medical profession has been crucial in determining the organisation of health services as a whole, while struggles within and between professional groups have had particular significance in maintaining non-integrated services for children (Honigsbaum, 1979; Armstrong, 1983). There have also been studies which have viewed child health services in terms of more general factors which lie outside medicine (Stacey and Davies, 1983; Davies, 1983b; Roche, 1981). These include changes in the class and gender orders, as well as certain economic factors.

Reference to the imposition or adoption of the Soviet model of health care delivery in Poland is also unlikely to be adequate as a unitary explanation of the division of labour in child health care

in that country today. The Soviet model itself drew on several sources, among them the British public health system.

> "The People's Commissariat of Health borrowed the system of wide prophylactic measures from British health protection, its class character from German insurance, and free and generally accessible medicine from Russian Zemstvo medical services."
>
> (quoted in George and Wilding, 1980: 106).

The legacy of British public health to Soviet (and Polish) health care lies in the dispensary system, which has come to form an essential part, not only of the child health service in Poland, as we shall see in the following section, but of the health services of the state socialist countries in general. The origins of the system have been traced to the Edinburgh Tuberculosis Scheme set up by Robert Philip in 1887 (Radiukiewicz, 1982; Armstrong, 1983). Armstrong refers to the scheme as the origin of a Dispensary system which involved

> "a new perceptual structure - a new way of seeing illness which manifested itself in different ways... Whereas the hospital and out-patient clinic had operated more or less within their own walls, the dispensary radiated out into the community. Illness was sought, identified and monitored by various techniques and agents in the community; the dispensary building was merely the coordinating centre"
>
> (ibid.: 8).

> "The Dispensary was a device, above all else, for making visible to constant surveillance the interaction between people, normal and abnormal, and thereby transforming the physical space between bodies into a social space traversed by power. At the beginning of the twentieth century the "social" was born as an autonomous realm"
>
> (ibid.: 10).

Yet the way in which the Dispensary system could be implemented was, and remains, quite different from that in Britain. For example, when the need for infant welfare was recognised in both Poland and Britain at the turn of the century, welfare centres were set up under the influence of the French gouttes de lait scheme: in Britain the first milk depot was opened in St. Helen's in 1899, while its Polish counterpart, krople mleka (a direct translation of the name of the French scheme) opened in Łódż in 1905. The main aim of the centres was to provide infant foodstuffs free-of-charge to very young children. There was in Britain an additional advice and surveillance function which was carried out by health visitors who visited the infants and their mothers at home. It is just this dimension of health care and the dispensary system, the entry into the home of health care professionals which has been consistently lacking in Poland. Here, the welfare centres were rapidly assimilated by the hospitals. The Łódż centre mentioned above, for example, distributed sterilised infant foodstuffs through pharmacies for a year before it was annexed to an out-patient clinic in the Anna Maria hospital in the same town (IMiDz, 1979).

Several factors militated against making the home the arena of health care. First of all, there is the role played by historical and political factors. From the end of the eighteenth century until 1918, Poland was partitioned between three centralistic powers and therefore did not possess a uniform structure of local government which might serve as the basis for such health services. The reconstitution of the Polish state and the establishment of local government gave some scope to the development of public health, although this was limited

by the fact that only 20 years were to elapse before the outbreak of war; when peace came, all the separate strands of child health care were to be superseded by a monolithic paediatric child health service. During the inter-war period the number of physicians employed in public health increased from 6,850 in 1923 to 12,917 in 1938, i.e. from 2.4 to 3.7 per 10,000 population (Polish Ministry of Information, 1941). In 1931 there were 205 health centres; six years later there were 482. The number of child welfare departments within these centres rose from 135 in 1931 to 364 in 1937, while the number of maternal aid departments rose from 107 in 1931 to 222 in 1937 (ibid.) (10).

More fundamentally, as was mentioned in the conclusion to Chapter V, the political Partition of the Polish nation induced a partition in Polish social life and social psychology which set apart the sphere of the state (the hostile partitioning power and its agents) and the sphere of "counter-state" or "society" (whose nucleus was the family, but which included subversive activities in the public domain). Under these circumstances, and given the degree of social consensus it requires, health surveillance carried out by employees of statutory bodies within the family was clearly not feasible. Whatever philanthropic home-visiting did take place before independence was unambiguously part of a strong counter-culture. The effects of this particular historical background are potentiated by the current Polish government's lack of political legitimacy, a question to which we return in the final section of this chapter.

Factors related to the gender order have also been closely

associated with the development of child health services in both Poland and Britain. If the social world in partitioned Poland was transected by a schism which divided state from society, then the dividing line which separated public and private spheres and relegated women to the latter, was not drawn so sharply as it was in Britain. On the one hand this meant that the home was less likely in Poland to be identified as the place where advice might be given to mothers, and on the other hand it meant that women experienced less difficulty in entering the medical profession itself. Many intelligentsia women who had been widowed during resistance to the partitioning powers subsequently became qualified and entered the professions.

In Britain public health and in particular infant welfare, was an important route for women into paid health work, first as health visitors and later as maternity and child welfare officers in the infant welfare clinics which were set up following the 1918 Maternity and Child Welfare Act. This was the first stage of women's re-entry as health care practitioners to a world where the practice of medicine had become firmly monopolised by men. Regarded as "inferior medicine" (Davies, 1983a), and operating in a world long-divided into public and private spheres, infant welfare developed its own ideas of prevention which incorporated welfare and education, was geared towards the surveillance of the working-class and considered women, especially middle-class women, as particularly suitable for this kind of work. In effect, a superficial sexual solidarity was invoked in a way it could never have been in a country split deep along political lines as in Poland, in order to gain entry into the private domain. Health visiting

> "drew on women's qualities - on the tender and sympathetic characteristics of women. It called on the kind of social relations already in use in the home and a vocabulary of friendship was invoked"
> (my emphasis - M.W.) (Davies, op. cit.: 2).

Similar themes in the work of the mostly female maternity and child welfare doctors prompted Stacey and Davies (1983) to postulate an "intermediate zone" between public and private domains as the locus for this type of health care activity. Interviews carried out by Roche in 1979-80 with CMOs and GPs in an attempt to elicit the perspectives on child health care of different professional groups, suggest that there is a degree of continuity between pre-war conceptions of infant welfare and views concerning child health today (ibid.).

While on the one hand the medical profession had never managed to establish itself as an exclusive male preserve in Poland to the same extent as in Britain, it was the specific employment and education policies of the post-war Polish government and the economic and ideological factors which prompted them, which provided the main impetus for the entry of women into medicine. By 1960, women represented just under 40 per cent of doctors, and by 1980 just over 50 per cent (RSOZ, 1981). In sociological investigations medicine emerged as the area of higher education most favored by Polish parents for their daughters (Kłoskowska, 1962), while public opinion over the post-war period switched from preferring male to preferring female doctors (11). Yet the structural changes and new values associated with women's changed occupational role at the same time accommodated to

traditional patriarchal notions concerning women's "natural" familial role as child-rearers. Many of the women who entered medicine became paediatricians, although precise quantitative data is unavailable in this regard since the Polish Ministry of Health and Social Welfare does not routinely collect data concerning the level of feminisation of the medical specialties - a fact which led to confusion in the allocation of manpower following the extensive take-up by women doctors of the paid child care leave introduced in 1981 (12). However, Sokołowska (1981: 105) has reproduced Polish data for the sixties which show that approximately 75 per cent of all doctoral and docentship dissertations in paediatrics submitted during the decade were written by women, easily the largest percentage submitted by women of all the branches of medical science considered. Moreover, according to the IMiDz internal annual report for 1979, four out of five Institute directors in that year were women, as were 11 out 21 departmental heads and seven out of 10 clinic heads, two clinic headships being vacant (IMiDz, 1980).

In Britain, the male monopoly of medicine has been crucial in determining women's entry into the profession; accounts of the legal barriers excluding women from medicine have been offerred by Sachs and Wilson (1978: 53-66) and Leeson and Gray (1978: chs 1 and 2). However, even after the lifting of formal barriers, Elston (1977) has shown that women's opportunities in medicine have been influenced less by particular social values, i.e. the degree to which they were "accepted" as doctors, than by specific changes in the medical labour market. This combination of circumstances has meant that women have entered

medicine much more slowly than in Poland; today they represent approximately one quarter of doctors working in the NHS (see Table 6.2).

TABLE 6.2: All doctors in post at 30 September 1984: showing percentage of women doctors and percentage of women doctors in paediatrics (Eng/Wales).

	All Doctors	Women Doctors	% Women Doctors
All Doctors Total	77,113	18,753	24.3
Hospital Doctors*	45,317	10,510	23.2
GMPS	15,316	4,622	18.3
CHS Medical	6,480	3,621	55.9
Paediatrics			
Consultants & SHMOs	573	98	17.1
Training Grades**	1,394	571	41.0

* includes permanent paid and honorary consultants, SHMO with allowance, Assoc. spec., Senior Registrar, Registrar, SHO, HO, Hospital Practitioner, Para. 94 Appts and ungraded staff.

** includes Senior Registrar, Registrar, SHO, HO.

Source: DHSS.

They continue, however, to represent over one half of community health service doctors, working in the child health centres and in school health, and are entering the lower grades of hospital paediatrics in significant numbers.

Notwithstanding these contrasts, orthodox medical thought differs little in Poland and Britain, with child health being viewed in both cases in terms of clinical surveillance. The translation of the clinical surveillance model into practice depends on many factors, not least

of which is the structural position occupied by the medical profession itself. This remains a key point of difference in the organisation of the child health services of the two countries, and is a question whose importance emerges in the following section.

Prevention and Cure in Primary Care

When the British National Health Service came into being in 1948, it did not have the unified and integrated structure which had originally been planned for it but one where, as a result of concessions made to conflicting medical interests, local authority doctors, GPs and hospital doctors remained organisationally distinct occupational groups. Within this tripartite arrangement, preventive and curative care for children were organised and provided quite separately. Although the GPs were the mainstay of a strong primary care system, they did not become family doctors providing both preventive and curative care in the way some had thought they might, but were largely curatively oriented. As Armstrong (quoted by Davies, 1983b: 23) has argued, the GP was "unable to conceptualise his position in terms other than those mediated by hospital medicine". Preventive care for pre-school and school-children on the other hand, something which both hospital consultants and GPs had been reluctant or unable to take on, remained the responsibility of the local authority health departments.

By way of contrast, Poland adopted from the outset a paediatric child health service, where cure and prevention were conceptually and

organisationally linked in the provision of primary care. The school health service remained outside the paediatric service until 1976, however, but although it was a basically preventive service, the medical personnel within schools did not lose the right to prescribe in the way local authority doctors had done in Britain. Primary care in rural areas, both preventive and curative, has also for the most part remained in the hands of non-paediatricians; this has been due to a failure to meet manpower demands within such a paediatric system rather than to the exclusion of rural health services from the system.

Although the organisation of primary health care showed quite fundamental differences in terms of organisation and delivery, nevertheless it was and is strongly dominated in both countries by hospital medicine. (In spite of the fact that doctors in Poland had lost professional autonomy, academic medicine continued to influence health policy through the medical personnel employed in the Ministry, the National Research Institutes and a national body of medical specialists (krajowy zespół specjalistów). In consequence, by the 1960s a paediatric model for preventive care for children had evolved in both countries which rested on clinical surveillance. In Britain this was marked most notably by the publication in 1967 of the Sheldon Report, while in Poland mass screening procedures which had been developed by the IMiDz were first introduced in 1963 to detect congenital abnormalities at birth.

Prior to this, the kind of preventive work which had been done after the war had in Poland been crucially influenced by three factors:

(a) the degradation of the biological base as a result of the war (in contrast with Britain where the distribution of welfare foods to children during the war had generally improved child health); (b) the epidemiological situation, i.e. the prevalence of infectious and deficiency diseases, and (c) the acute shortage of medical manpower. During the 1950s, mobile units and health propaganda had been the solution for minimum coverage in a situation of severe manpower shortage. Welfare concerns were expressed in the setting up of "milk kitchens" (kuchnie mleczne) which dispensed infant feeds at cost price until 1954 and later free-of-charge for a period of up to one month (13). Throughout the fifties, the guidelines for the work of the school doctor also included a welfare element. It was in her power to decide whether a child would benefit from a summer or winter colony holiday, and whether he or she was in need of nutritional supplements such as cod liver oil or vitamins (14). Physical examinations were carried out once a year and for some age groups, more than once a year (Rada d/s Rodziny, 1979e). The other important aspect of prevention in the fifties was the fight against infection. This usually took the form of "campaigns" against particular diseases. The health legislation of the period is littered with instructions on procedures to be adopted in the case of diseases such as tuberculosis, trachoma, child diarrhoea, and the deficiency disease rickets. During this decade the infant mortality rate fell by almost 50 per cent (See Table 3.1).

The 1960s were a decade of transition in the child health services in Poland. The policy of employing feldshers, who had been useful as long as the critical deficit of qualified medical personnel lasted,

was reversed and those already employed were encouraged to retrain as doctors. Those services whose concern it had been to provide a measure of welfare were phased out and a dispensary system phased in. This system, whereby children were classified into dispensary groups for treatment, developed in piecemeal fashion and had been effective in dealing with tuberculosis.

The fundamental reorganisation of the NHS and of the Polish health service which took place in the mid-1970s show certain broad similarities. Both were associated with a reorganisation of local government and in both cases there was a concern for integration, that is to say, with the unification of the various aspects of health care provision.

In Britain, the Hospital Management Committees and Regional Hospital Boards which had been responsible for the running of the hospitals were abolished. Their functions, together with the functions of the local authority health departments were transferred to district, area and regional health authorities. The local authority medical officers were restyled clinical medical officers, while the medical officers of health became specialists in the new community medicine. At the same time it was hoped that liaison between the local authorities and the health authorities would be fostered through the coterminosity of the new local authorities and the AHAs, and through the creation of joint consultative committees. On the other hand, the Seebohm Report had recommended the creation of new personal social services departments within the local authorities, and this

taken together with the shift of responsibility for preventive child health care out of the local authorities meant the shedding of any element of welfare in the new idea of community medicine (cf. Stacey & Davies, 1983: 42).

However, these were all administrative changes which left the pattern of child health services virtually unaltered; a consideration of the division of labour in the delivery of child health care did not come until the publication of the Court Report (HMSO, 1976) two years after reorganisation. The Report considered and rejected the option of a unified paediatric system such as that in Poland. On the one hand the Report stressed prevention and was concerned that an integrated child health service would be available from paediatrically-trained medical personnel. On the other, it took care that its proposals should be tailored to the existing institutional framework, which in this case meant taking into account the central position of GPs in primary care. In essence, these proposals were that both curative and preventive aspects of primary care should be in the hands of paediatrically-trained GPs (General Paediatric Practitioners) assisted by child health visitors, and that this care should be supported by the community paediatrician, who would be based in the hospital yet practise also within the community. Much of the argument for these proposals rested on its child and family-centred approach, and on the advantages of primary care for children being administered by doctors who also treated their parents (15). But although the proposals were accepted in principle, they were not implemented (16), and the GPs found the idea of specialist training generally unacceptable.

At this time also, the DHSS began to publish a series of documents highlighting the role of prevention. Analysing one of these documents, Graham (1979), has shown how the idea of prevention they propagated was based on a notion of health as being primarily a matter of individual, rather than social, responsibility, and as being dependent on lifestyle. Davies (1983b) has further sought to place these ideas of prevention within an economic context of austerity.

While this public debate continued, group practices and health centres proliferated, and increasingly GPs as part of a primary care team were taking on preventive work with pre-school children but were notably expressing little interest in school medicine. Their professional association, the Royal College of General Practitioners, had also made a decision in the late 1970s to enter the debate concerning the place of prevention, and a series of reports were published on this subject; the largest of these dealt with child health surveillance and was entitled Healthier Children - Thinking Prevention (RCGP, 1982) (17). Again, the approach in this report is a family-centred one; since the family and relationships within the family are what constitutes the child's environment, and preventive work must take place within this environment, then it is argued that GPs are in a unique position to provide integrated curative and preventive care for children - such work in other settings is dismissed. Within general practice prevention is seen as involving the maintenance of health records for every child; it includes primary, secondary and tertiary prevention. As Davies (1983b: 12) notes, while the report is clear about what constitutes secondary and tertiary prevention, i.e. developmental assessments

to screen for defects and the prevention of deterioration of defects in those who already have them, it is much more vague about what, apart from immunisation, constitutes primary prevention.

> "To be 'thinking prevention' is to be looking from the child to the other family members and to the quality of their relationships. This appraoch will be backed up with a programme of child assessments. All of this marks a considerable change in the way GPs have traditionally thought and acted, but it is still a narrowly focussed notion of prevention"
>
> (Davies, op. cit.: 16).

This work, it was proposed, could be done by GPs without them having to undertake any further specialist training. They would take over the tasks they had always regarded as trivial, those performed by the clinical medical officer, and to some extent those of the health visitor also, if an appropriate payment system could be devised, while the primary care team would be widened to include a practice nurse to carry out routine tasks.

> "If this does occur, we should see it together with the restructuring of the work of the Medical Officer of Health in 1974 and with the question marks hanging over the clinical medical officer and the health visitor. It will mark the end of the separate, medically-oriented, preventive health worker - a more fundamental shift in the division of labour in child health care than was achieved in 1948 or 1974"
>
> (ibid.: 29).

The reorganisation of the Polish health service was also concerned with integration, but the central problem was not with prevention as such, although important changes were made to the school health system,

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The reorganisation of the Polish health service was also concerned with integration, but the central problem was not with prevention as such, although important changes were made to the school health system,

but rather the integration of primary care as a whole with hospital services in order to strengthen the former. Although the 1974 reorganisation of the NHS had been concerned to integrate local authority and hospital services, general practice had been relatively uninvolved in these changes. The Polish reorganisation was also the occasion for the publication of a set of instructions, rather than proposals, concerning child health care within the reorganised service: The Programme of Health Care for the Developmental Age Population 1975-1990 (18), with a parallel and separate programme dealing with ante-natal care.

Jointly developed by the MZiOS and the IMiDz, the child health care programme consolidates the trends which had been apparent in the 1960s and sets out the new pattern for the delivery of health care to children, and the ideas which underly it. One of the claims to novelty in the programme lies in the definition of the population with which it is concerned. By extending the period of the life-cycle with which it deals to include both the period of foetal development and children up to 18, a new "developmental age medicine" (medycyna wieku rozwojowego) is created. Stress is placed on the importance of genetic and environmental factors in prevention: there is "evidence that many children do not reach their full developmental potential because of the action of disadvantageous environmental factors before and after birth. This calls for a new strategy in health care" (Bożkowa, 1978: 8). The environmental factors involved here are

> "the health of the parents, especially the mother - both before and during pregnancy, conditions in the family, day nursery, nursery school and school,

> on the assumption that the quality of life is the result of interaction between genetic and environmental factors".
>
> (ibid.).

Whereas this might be taken to indicate a concern for welfare or primary prevention in a broad sense, the fact is that apart from the identification of the mother as an environmental factor and the development of family medicine around this concern, there is a dissociation between this declaration and the scheme of preventive care which is put forward. It is clear that they way in which the family is construed here has little in common with the view put forward in Healthier Children - Thinking Prevention, and family medicine equally little with the Balint-type medicine influenced by psychology and psychoanalysis which is practised by some GPs in Britain. In Poland, the notion of "family health" has found its institutional expression in the creation within the IMiDz of a Department of Family Health. The family is viewed here solely as a reproductive unit: the possession of a child is "the greatest good and goal of every married couple, not only newly-weds" (IMiDz, 1980: 257), and this is reflected in the activities of the Department. Medically, the Department is concerned with the treatment and prevention of infertility in men and women, the health care of the foetus and children up to 18 years, and the prevention and treatment of sexual disorders among married couples. It also engages in educational and counselling activities such as premarital counselling, schools for parenthood, genetic counselling, anomymous counselling for young persons, and sex counselling and education.

In fact the scheme which is put forward rests, in addition to an innoculation regime, on an interlocking system of screening tests, health balances and a dispensary system of active care. It also features the integration of educational medicine into the paediatric system, the details of which are discussed separately in the following section. It does not, as Healthier Children - Thinking Prevention did not, present any broader idea of primary prevention, for example in relation to the role of day care. A national programme of standardised screening and health balance procedures was established (Table 6.1) not very different from the basic surveillance programme which appeared at the same time in the Court Report in Britain. The store set by the system was great:

> "it is to be expected that when it is fully implemented, the system of health balances and active dispensary care will have the same significance for the reduction of clinical states associated with developmental and chronic disorders as did innoculations for the elimination of morbidity and mortality caused by many infectious diseases"
>
> (Rada d/s Rodziny, 1979e: 46).

By 1979, 80-90 per cent of the child population (100 per cent in older groups) were included in the programme (ibid.).

The health balances - also referred to as "universal in-depth medical examinations" - were intended to provide a "balance-sheet", firstly of the health needs and adaptational capacity of the individual by analysing his/her state of health and development and secondly, of the epidemiological distribution of positive and negative phenomena in a given population. This is accomplished by means of the standardised

record-sheets of the screening tests and other diagnostic procedures undergone by each child. The balances are carried out at birth, and then at 2, 4, 6, 10, 14 and 18 years of age, and are seen to have three basic aspects:

(1) there is a "balancing up" of the results of any screening tests which a child has had since its last health balance;

(2) there is a medical examination, the nature of which depends on the child's age, and

(3) a documentary record is held for each child which lays out the programme of dispensary care required, and which may also be used for the epidemiological purposes mentioned above.

Although a child may be referred to a dispensary group as the result of any medical consultation, the screening tests and health balances as instruments designed for the early detection of subclinical states are particularly important in this regard. Since none of these tests is performed within the child's home (except possibly for one shortly after birth), the system depends on a high attendance rate at the well-child clinic of the neighbourhood polyclinic, particularly in the case of pre-school children who attend neither day nursery nor nursery school. Clinic attendance is also crucial in Britain, where surveillance does not take place in day nurseries or nursery school.

The dispensary groups themselves are structured according to the content of the health balances and are designed to cover the most frequent defects and diseases - a list of these is shown in Table 6.2. The principles and standardised procedure involved in each dispensary

TABLE 6.2: Classification of Dispensary Groups (Poland)

Group	Classification
I	Perinatal risk
II	Congenital disorders
III	Chronic nutritional and deficiency disorders
IV	Disorders of physical and mental development
V	Disorders and diseases of the visual organs
VI	Chronic diseases of ear, nose and throat, speech and hearing defects
VII	Chronic diseases of the respiratory tract
VIII	Diseases and disorders of the circulatory system
IX	Chronic diseases of the urinary tract
X	Permanent disorders of the locomotive organs and posture defects
XI	Other chronic diseases calling for active care

Source: Radiukiewicz, S. (1982), pp. 11-12.

group have been elaborated by the IMiDz and issued by them in the form of printed instructions, as is the case with the health balances. The first or "zero" health balance is carried out by the doctor in the neonatal ward. Here, all infants are screened for phenylketonuria. Where there have been complications during pregnancy or the perinatal period, infants are referred for active care in dispensary group I, the perinatal risk group, where they are subject to surveillance, in principle until their second health balance at two years. The health balance of two year-olds aims primarily to detect defects of vision and hearing, as well as any congenital abnormality which might not have already been picked up. It also includes psychomotor and adaptational testing.

The balance carried out at four years is designed to detect speech defects in addition to those of vision and hearing. Detected abnormalities at this stage might lead, for example, to referral to dispensary group II - congenital abnormalities, dispensary group IV - abnormalities of mental and somatic development, or dispensary group V - defects and diseases of the visual organs, etc. The health balance at six years evaluates a child's readiness for school, while the examination of ten year-olds is intended to ascertain their level of adjustment to school and school work; it is also intended to be used as the basis of assigning pupils to the P.E. group which is appropriate for them. At 14 years, children are examined to determine their level of sexual maturity, and with reference to the type of secondary education to which they wish to proceed. Finally, the balance at 18 years is designed to ascertain the young person's readiness for life outside school.

In contrast to this nationally standardised programme of health surveillance, the pattern of preventive services in Britain in a very heterogeneous one. Nevertheless, the general principles of surveillance and the range of health risks covered are similar. Davis and Strong have described child health surveillance examinations in four settings: the maternity ward, the special nursery follow-up clinic, the local authority clinic, and the special neurological clinic (Davis and Strong, 1976; Strong, 1979; Davis, 1982). Here, infants are checked on birth, and those presenting complications are removed to a separate nursery. There is a subsequent examination of the children in the maternity ward, where except in special cases they remain with their mothers. Local authority screening was scheduled for all children of

six and twelve months, although those who had been previously identified tended not to appear. These children, that is those who had been admitted to the special nursery in the maternity hospital, were seen in the special nursery follow-up clinic at ten months. Davis and Strong were also concerned with the tone and interpersonal dynamics of these examinations. Polish studies have been further from this kind of consideration than those in Britain. The recent study which has been made of the working of local children's clinics in 18 ZOZy in the Łódź voivodeship concentrates on measuring the length of time spent waiting and in consultation (Szeszenia-Dąbrowska, N., Gdulewicz, T., Sapiński, W. and Klata, H., 1981a; 1981b). The average time spent on a preventive examination is 6.2 minutes, which the authors point out leaves no time for health education; health propaganda in the form of wall posters took the place of such education.

There are few studies of the efficiency of such arrangements, as has been pointed out in a recent review of research.

> "There is a great variety of patterns of service, involving health visitors, clinics and different arrangements of general practice, with little assessment either of their efficiency or of the consumer's preferences"
>
> (Blaxter, 1981: 223).

This is exacerbated in Poland by the failure to follow up the extent to which referral for dispensary care is followed by treatment, a key question if the system is to function properly (19). There is evidence that the Polish system can fail for chronic disease; this is provided by the history of care for diabetic children. Because their

health and welfare needs were patently not being met within the system, a self-help group of parents and professionals was formed in 1978 under the auspices of the TPD (20). In addition to organising special health colony holidays for diabetic children (21), this Diabetic Committee has found it necessary to engage with various state institutions in order to secure insulin supplies, sugar-free foodstuffs, travel concessions (i.e. priority in queues) and other facilities necessary for welfare. It has also found it necessary (despite integrated school and paediatric care) to work to increase the awareness of schoolteachers concerning diabetes. At present, the Committee is the national distributor through its local groups of the disposable needles and syringes needed by the children but unavailable through the health care system. The lack of adequate supplies of pure insulin (Polish insulin is of poor quality, and so foreign insulin must be imported), has meant frequent crises with children ending up in hospital on hospital insulin. To avoid this local groups have formed insulin banks. As of 1982, no solution to the insulin problem had been found, with the state authorities once agreeing to the necessary imports if the TPD define the extent of the requirement (routine data on diabetes amongst others has not been collected by the polyclinics since 1970), and once claiming that no need for such imports exists.

The problem of non-compliance with a health surveillance programme, as mentioned earlier, is one which has to be faced in both Poland and Britain. One way of dealing with this in Poland has been to time screening procedures to coincide with the compulsory immunisation

schedule, and in general the health balances, if not the intervening screening procedures, are observed. The question has not been subject to the same volume of research as in Britain (cf. Roche and Stacey, 1984), where the solution has typically been sought in the deployment of the health visitor. (This is a decreasing practice; in 1966 health visitors saw 87 per cent of under 5s in their own homes, but only 77 per cent ten years later (CPRS, 1980: 31)). Thus the ultimate recourse in the case of non-attendance in Poland involves a legal sanction, while in Britain it involves domiciliary visiting.

In general, factors which affect the use of services have been little researched in Britain (Blaxter 1981), although Graham (1984) has indicated that these may be complex. In Poland this is an issue which remains far below the surface, where the mainstream of thought has been concerned with the formal organisation and provision of services.

School Health

The position of school health is a vexed one in both Poland and Britain. Regarded at the beginning of the century as a key way of improving the health of children, school health in Britain has more recently become eclipsed in the debate on child health services. Information concerning the functioning of the school health service is hard to come by. Before the reorganisation of the NHS, the chief medical officer to the DES published a bi-annual report on the work

of the school health service; this was discontinued in 1974. The dearth of research in this area has also repeatedly been indicated (Morris, 1980; Blaxter, 1981; Whitmore and Bax, 1982; Roche and Stacey, 1984). Another reason for the failure to incorporate school health in the general debate are the difficulties in accommodating the specifity of school health with the view which sees prevention as the kind of surveillance work which can be done by GPs in their practices. On the one hand educational medicine has tended to be identified with developmental screening, and therefore as something which can be carried out by GPs, yet on the other, there has been a reluctance for GPs to be involved in school health (as opposed to preventive work with pre-school children). Voices have, however, been raised among child health doctors which do call for the environment of the school, as well as that of the home and family, to be taken into account in the planning of services, and which challenge the view that GPs are unique in their access to knowledge of the family environment:

> "to consider the child in the context of his home and family is not the prerogative of the family doctor, nor is it essential only when the child requires treatment. There are other ways of obtaining information about home and family than being in a position to treat all its members when they are taken ill, and school doctors regularly obtain and use such information in the course of promoting children's health and development"
>
> (Whitmore and Bax, 1982: 55).

The argument these authors put forward is that therapy should be included in school medicine, and that there must be a degree of overlap between school and GP services if one is to be sure of reaching all

children. This overlap "must consist of the facilities and the competence on the part of both GPs and child health doctors to adopt an integrated role when they examine certain children" (ibid.).

The unification of the educational and paediatric health service in Poland was a major feature of the reorganisation of the health service which took place in the mid-1970s. Broadcast in 1973, it was intended that by 1985 all Polish children would be receiving integrated care (Rada d/s Rodziny, 1979e). The role of educational medicine had been the subject of debate and innovation throughout the post-war period. Before the second world war and up to 1973, school health had been held quite separate from other child health services, much as it has remained in Britain to date. In the 1950s, one noted Polish specialist in social medicine (22) presented his view of what a school health service should be by drawing an analogy with the newly developing industrial health service:

> "the pupil in fulfilling his obligations to the school is like his father, the working man. Except that in working at school he should also be developing properly, which is an extra burden of sorts. And for that reason he should have health care at school which is in no way inferior to that available to his parents at their places of work."

This was a call to widen the scope of the health care offerred in schools. The growing criticism of the split between prevention and cure, and of the isolation of the school doctor led with the 1961 legislation to an expansion of her therapeutic role. The range of therapy to be provided in schools included dental care, orthodontic, orthoptic

and orthopaedic treatment, speech therapy and other forms of therapy which were often also provided on health colony holidays. This was the position until 1973. During this time there were again criticisms of the expense involved in running parallel therapeutic and preventive services and of the fact that more than one doctor was caring for the same child, and experimental attempts were made to provide integrated care on a local basis. The first of these was in Sopot in 1964/5. It was established that certain criteria must be met if integrated care was to be effective:

(1) the number of children per rejon paidiatrician should not exceed 800-1,400 depending on the organisational variant in operation;

(2) the school catchment area and paediatric rejon should overlap by at least 75 per cent;

(3) the operation of a shift system in schools would be a serious hindrance to the functioning of a paediatric-school rejon;

(4) the organisational variant must be adapted to local conditions. The "Sopot" variant where one doctor is responsible for all children aged 0-7 years and another for those aged 7-15 suits large towns with a high population density. The "Poznań" variant where one doctor deals with all children aged 0-15 years is more suitable for small towns where there are fewer doctors, or in new housing estates where day nursery, nursery school, primary school and polyclinic are all situated close together;

(5) the efficiency of paediatric-school care depends on the

work of school nurses, who should continue to be employed regardless of the organisational variant in force;

(6) the paediatric workforce must be stable and have an adequate training for the preventive tasks they are required to perform, and also for the numerous ascertainments they must make. Doctors who previously were employed in schools should undergo some clinical paediatric training and be employed as far as possible in schools;

(7) specialist back-up is necessary not only for the needs of pre-school children, but also for the specific needs of school age children

(Serejski, 1978).

In the event, these criteria failed to be met. The conditions which had not been met were:

> "a stabilised workforce ...; continuity of care (in practice it is exceedingly rare to find a case where a doctor is able to be responsible for all children aged 0 to 15 years); overlap of paediatric-school rejony ..., for example, in Warsaw in most rejony the overlap between paediatric rejon and school catchment area is less than 50 per cent; the observation of norms concerning the maximum number of children per paediatric-school rejon doctor (in some areas this number exceeds the norm by three or four times); the integration of health documentation and its cirlation between clinic, nursery school and school (in practice this does not exist; where records are kept they are separate, therefore incomplete)"
>
> (Służba Zdrowia, 1981).

Although records of the numbers of children referred to dispensary groups were rigorously maintained (10-20 per cent of children in

each paediatric rejon have been estimated to require "dispensarisation" (Radiukiewicz, 1982)), as has been mentioned there was no strict follow up to determine to what extent referral entailed treatment, and sometimes it did not. This was a reversal of the system's declared scheme of priorities whereby the individual was to take priority over the epidemiological aspect of the examinations. The School Medicine and Hygiene Section of the Polish Paediatric Association and the School Hygiene Section of the Polish Hygiene Association criticised the haste with which the programme of integration had been introduced, writing that the

> "lack or limited opportunities for cure, corrective treatment and rehabilitation in the case of abnormalities in health or development which have been revealed, means that their rearly detection will be of no significance for the improvement of the health of the individual or the population. Already we can see the socially harmful danger of a widening gulf between the number of abnormalities detected and cured, with at the same time a lack of anyone who is responsible for this state of affairs"
>
> (ibid.).

In a study carried out by Serejski and Florek (1979), the discontinuity between diagnosis and treatment was found to be particularly worrying in the case of children from rural areas. This was seen to be due to the fact that although these children do have access to primary care, they do not have access to systematic specialist care. One way of making up for this is the "equalising holiday" (turnus wyrównawczy), during which intensive corrective treatment has been shown to have positive results (23). The turnusy wyrównawcze form part of the health colony holiday system, which in turn caters for children who do not

qualify medically for ordinary colony holidays. Here too, need far outstrips supply. A potential demand for 300,000 places per year has been estimated, together with an additional 200,000 places for children, usually with speech or posture defects, or disorders of binocular vision, who have been unable to get corrective or rehabilitative treatment at home during the school year because of a lack of facilities within the health and education systems (Radiukiewicz and Chojnacka, 1980). In fact, 70,815 Polish children enjoyed a health colony holiday in 1980 (Ministry of Education statistics) (24).

Plans to include 15-18 year-olds in the integrated system had to be shelved.

> "In spite of the fact that they formally receive care, this age group is not ensured adequate diagnostic and therapeutic care, either inpatient or outpatient. The preventive care given by doctors in secondary schools and in the industrial health service is not linked to cure, corrective treatment or rehabilitation. The reason for this is a lack of access to the appropriate Specialists both at ZOZ and voivodeship level"
>
> (ibid.).

Elsewhere, it was preventive care which tended to go by the board with priority in the system going to sick children, and also to preschool children whose needs are generally recognised to have been relatively well met.

Behind this lay severe manpower problems. School nurses were key workers in the school health service, as they are in Britain, and following the introduction of the dispensary schedule the demands made

of them were even greater. Yet there were few of them; in 1981 there was only one nurse for every nine educational establishments in Poland (IMiDz, 1982). There was also a shortage of suitably qualified medical personnel.

> "Throughout the country there has been a decline in specialisation in school medicine. The number of people choosing this specialty has decreased. The basic reason is the deficit of doctors with a first degree paediatric specialisation, and in some areas the negative attitude towards this specialty on the part of regional or voivodeship health service administration and technical control (Poznań, Warsaw). This situation makes it impossible to observe, in accordance with MZiOS recommendations, the principle that school health clinics should be staffed by doctors with a second degree specialisation in school medicine. In most cases the ZOZ school health clinics operate a system of "watches", since doctors are employed there on a sessional basis for a few hours per week. Such clinics are not able to carry out their basic statutory responsibilities. Such a situation has been ascertained, for example, on visits to Mońki, Puck, Płock and other ZOZy. In this respect the situation is better in the large towns.
>
> In many areas the linking of rejon (paediatric) care and school care represents sham integration: surgeries for sick children, home visits, and so-called prophylactic care within the school, are carried out by <u>different doctors</u> with respect to the same child. As a result the intended effects of integration are lost and a deterioration has been ascertained in preventive school care as compared with the former organisational model."
>
> (IMiDz, 1980a: 125-126).

Clearly, lack of professional autonomy in Poland has not prevented factors which are essentially of an intra-medical nature from having a marked effect on the pattern of health services as they are

delivered. While in the discussion which has gone before, the medical profession and the structural divisions within it have been seen to have played an important role in determining the nature and place of prevention within child health care in Britain, the problem in Poland, has been typically identified as the need to strengthen of weak primary care within a strongly hospital-dominated system.

However, the improvement of the Polish health care system scheduled for the 1970s was cast by the authorities in context of increased prosperity and investment and rested on an assumption that increases in staffing levels and the improvement in the material base of the services were sufficient to bring this about - and much of the criticism of the system was couched in the same terms. The devastating critiques offered both by the DiP Report (DiP, 1981) and the KOR document on the State of the Hospital System (Millard, 1981) engage with the health care system primarily in material terms, seeing underinvestment in health as the major factor in the decline of the services. Clearly this aspect of provision should not be underplayed; during the years 1976-1980, national spending on health represented 3-4 per cent of the GNP in Poland (Loch, 1980) (25), while Britain, regarded as a low but effective spender on health, the figure for 1980 was approximately 5 per cent (Levitt and Wall, 1984). The data presented in Chapter I has indicated just what a devastating effect on health underfinancing of the health service can have.

Other analysts have identified problems in the rigidity of the planning system (Webster, 1982), or in the dysfunctional role of

"bureaucratic centralism", that is, the refusal to delegate decision-making to the periphery. Foremost among the latter critics is Professor J. Indulski who heads a commission concerned with organisational changes in the health service (komisja d/s zmian organizacyjnych).

Where social consciousness is almost totally dominated by the polar relationship between state and society, it is perhaps not surprising that there has been little consideration of the role of medicine and the medical profession itself in shaping health services. The importance of intra-medical factors has been noted by Mackiewicz (1981), but his request for a debate of such issues met with no response from the medical profession. This represents a formidable barrier to improvement in health services, for although the weakness of primary care is agreed to be the central problem, the disparate groups set up by the MZiOS in the wake of Solidarity to work out proposals for health service reforms remain almost exclusively peopled by members of the medical profession.

Availability and Use of Services

The socialised health care systems of both Poland and Britain today offer medical care which is free at the point of delivery. The taxation-based National Health Service was informed by the universalistic ideology of Beveridge's post-war welfare proposals and brought free medical care to women and children for the first time. On the other hand, Poland's publicly financed system was introduced on a strictly

selective basis, being mainly oriented towards the needs of industry and the socialised sector of the economy with mothers and children a preferred client group (26). Until 1972, the private land-owning peasantry was not entitled to free health care; their children were eligible for free preventive care and free therapeutic care in the first year of life and inasfar as such care was available in schools. Today about one per cent of the population remains outside the socialised system. These are craftsmen or those engaged in private enterprise.

It is beyond doubt that the limitations imposed on market forces by these socialised systems, inasfar as they exist and are maintained, have made access to medical care more equal than it might otherwise have been. This having been said, Hart (1971) has noted the existence of an "inverse care law" in Britain whereby the "availability of good medical care tends to vary inversely with the need for it in the population served". However, insofar as the provision of health services after the war was geared to the needs of industry in Poland while the British authorities failed to accord priority to the construction of health centres in industrial areas, the inverse care law (to the extent that it may be ascertained to exist) does not operate by means the same mechanisms in Poland as in Britain. The same is true of the distribution in towns and cities of primary care doctors. In Britain, there is a tendency for GPs to prefer middle-class areas in which to work with the result that poorer and more deprived areas are often served by fewer GPs with longer patient lists, despite the power of the Medical Practices Committee to prevent GPs from going to over-doctored areas. Class in these terms does not operate to the same extent in determining

the distribution of doctors in urban areas in Poland. The catchment areas of the neighbourhood polyclinic are administratively drawn up, and are subject to a lesser degree of geographical concentration of socio-economic groups. Access to care is in any case not totally defined by what is locally available: there is subversion of the territoriality of health care insofar as outpatient facilities at every level of the service are open to self-referral. A more significant mechanism for the functioning of an inverse care law in Poland may be the social origins of doctors. A national study carried out in 1978 showed that while 7 per cent of medical students had fathers who were peasant farmers and 2 per cent had fathers who were unqualified labourers, 24 per cent had fathers who worked in administration and 18 per cent had fathers in the professions (figures provided by Instytut Medycyny Społecznej, A.M. w Łodzi).

The infant mortality data which were considered in Chapter I have indicated the closeness of the relationship between health and social deprivation in both Poland and Britain. This is confirmed in Britain by the social patterns of child mortality in the case of many but not all causes of death. Longitudinal studies also provide evidence concerning the link between occupational class and child morbidity, although the regularly published interview-based GHS data are more equivocal in this regard (Blaxter, 1981). In Poland, figures which present child mortality or morbidity rates according to the educational level of the mother, or some other index of social deprivation are unavailable, with the exception of the infant mortality study discussed in Chapter I. In both countries, studies which view access to health services in tems

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need are lacking (Sokołowska, 1978; Walters, 1980, Blaxter, op.cit.), although in one study carried out under the auspices of the WHO, Salkever (1975) found that low-income children enjoyed less access (defined as a need-entry probability) to medical care than high income children in all of the five countries he studied, including both Poland and Britain. The only source for national data concerning children's consultation rates in Poland comes from a study conducted between July 1967 and June 1968 by the IMiDz, using a sample size of 1,000 children in each of five age groups. The results of this study are summarised in Table 6.3. The study only distinguishes children by sex

TABLE 6.3: Annual consultation rates per 1,000 in rejon polyclinic (Poland, 1967/68)

Age group	All	Urban	Rural	Male	Female
0-1	3,450	4,730	2,470	3,620	3,260
1-4	2,020	3,160	1,110	2,060	1,970
5-9	1,390	2,160	740	1,370	1,400
10-14	1,200	1,720	720	1,110	1,290
15-19	1,470	1,880	1,000	1,580	1,360

Source: Krzysztofowicz, I. (1977), pp. 41-44.

and age, and according to the urban/rural administrative division. Though it fails to deal with variations within urban and rural groups, nevertheless it does indicate the existence of an inverse law of kinds in terms of this divide, which is a rough approximation to the structural split between the peasantry and the rest of the population. Krzysztofowicz (1977: 75) has written of rural children that "significant differences are still to be found in comparison with rural children.

Comparisons of developmental indices, indices of nutrition and state of health which have been carried out by many authors show rural children to be disadvantaged". Notwithstanding, the 1967/68 study revealed large discrepancies in children's consultation rates in urban and rural areas. Table 6.3 shows that rates for children under one year of age were almost twice as frequent in urban as in rural areas; for children in the 1-4 and 5-9 age groups it was almost three times higher; among 10-14 year olds it was two and a half times higher and among 15-19 year olds it was almost two times higher. How far these differentials would persist if the study were to be repeated now, when therapeutic care is available free-of-charge to all peasant children, and not just those under one year of age as at the time of this study, it is hard to predict. The extension of eligibility for free health care to 6.5 million peasants in 1972, a 20 per cent increase in the population served by the socialised service, was not accompanied by increased investment and staffing (ibid.: 75), and the staffing disproportions between urban and rural areas in all professional categories remains great, as may be seen from Table 6.4. As far as the peasantry as a whole is concerned, Ignar (1980) has referred to work done by the Institute of Rural Development at the Polish Academy of Sciences which indicates that the increase in take-up of services by the peasantry following 1972 has not been large; non-use of primary health care facilities fell from 63 per cent before the introduction of free treatment to 50 per cent afterwards. However, figures which refer to children as a specific group are lacking.

TABLE 6.4: The distribution of health manpower in urban and rural areas (Poland, 1970-1980)

			1970	1975	1980	Rural level as percentage of national level (1980)
Total Employed	Year		1970	1975	1980	
	Total doctors		46,466	54,461	63,577	5.6
	No. of doctors per 10,000 pop.		14.2	15.9	19.0	-
	Dentists		12,966	15,114	16,834	14.5
	Feldshers		4,641	4,264	3,747	20
	Nurses	Total	98,569	122,600	156,967	6
		Fully qualified	78,173	105,946	146,050	6
		Total per 10,000 pop.	30.2	35.9	43.9	-
	Midwives		11,553	13,369	16,092	9.4
Rural Health Service	Total doctors		2,455	3,484	3,551	
	No. of doctors per 10,000 pop.		1.6	2.3	2.4	
	Dentists		1,867	2,503	2,445	
	Feldshers		956	857	759	
	Nurses	Total	3,992	8,355	9,640	
		Fully qualified	3,096	7,074	8,963	
		Total per 10,000 pop.	2,6	5,5	6,5	
	Midwives		1,544	1,539	1,519	

Source: Compiled from RSOZ 1979, Table 6, pp. 158-159; RSOZ 1981, Tables 1 and 7, pp. 181 and 188.

In Britain, evidence has been provided by the National Child Development Study and the Child Health and Education in the Seventies study which points to an inverse relationship between clinically defined health need and use of preventive services (Blaxter, 1975, 1981; Townsend

and Davidson, 1982). This is true of immunisation, dental care and the use of child health clinics. About one half of under 5s now attend child health clinics each year, although there is wide variation by age, with three quarters of under 2s attending, but three quarters of 2-4 year olds not attending (CPRS, 1980). Among the ranks of non-attenders there are proportionately more from occupational classes I, IV and V. Moreover, "(m)any non-attenders ... apparently neither visit their own GP nor seek visits from HVs in their own homes as alternatives to visiting clinics" (ibid.: 32).

Data concerning the use made by children of curative medical services are rather sparse, as is the information on the use of preventive services, and British studies in this area have been criticised as being rather superficial and lacking in theoretical context (Blaxter, op. cit.). The sources of available non-hospital data in this case are the Morbidity Survey of 1955/6, the National Morbidity Survey of 1970/1, which did not use occupational class categories, and the continuing annual interview-based GHS. The 1955/6 Morbidity Survey results are presented in Table 6.5, while GHS data for 1971/2 and 1982 are given in Table 6.6. Neither of these sets of data shows a clear pattern consultation; they do not confirm the trend to lower rates with decreasing occupational class found with adults. More thorough and up-to-date research in this area has been called for (ibid.).

Comparison of Polish and British child consultation rates (Tables 6.3 and 6.5) shows a general and shared tendency for boys to

TABLE 6.5 : Annual consultation rates per 1,000 in general practice (Britain, 1955/56)

		Occupational class of father				
		I	II	III	IV	V
Males	0-1	828	803	826	821	812
	1-5	712	766	786	743	759
	5-14	657	652	681	643	605
Females	0-1	761	788	821	835	764
	1-5	671	703	781	712	731
	5-14	634	639	683	648	635

Source: 1955/56 Morbidity Survey reproduced in Blaxter (1981), Table 10.2, p. 169.

TABLE 6.6: General practitioner consultation rates per 1,000 in a two-week period (Britain, 1971/2 and 1982).

		Occupational group of father											
		1		2		3		4		5		6	
		(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Males	0-4	203	77*	142	164	154	184	145	147	135	168	94	24*
	5-14**	44	33	79	27	74	36	68	30	71	14	64	100*
Females	0-4	134	130	159	102	156	132	164	114	123	184	95	99*
	5-14**	57	12	69	12	65	52	66	30	68	52	61	42*

(a) 1971 and 1972 combined

(b) 1982

* Based on small numbers

** 5-15 in 1982

Source: Compiled from Blaxter, M. (1981), Table 10.3, p. 170; GHS 1984 , Table 8.24, p. 175.

consult more frequently than girls, coupled with substantially higher overall consultation rates in Poland. To some extent this is explained by the fact that the Polish figures refer to both the preventive and curative consultations which take place in the rejon polyclinic; the British figures on the other hand exclude consultations which take place in the child health clinic and the home visits of health visitors, which form the backbone of the preventive care system for pre-school children. (Both studies exclude self-referral to accident and emergency hospital departments - an option found to be more frequently used by lower socio-economic groups in Britain - while the Polish figures also exlude self-referral to specialist outpatient clinics). Although it is difficult for these reasons to draw a hard and fast comparison, nevertheless the Polish consultation rates do appear to be significantly higher, being over four times more frequent in the 0-1 year age group, approximately three times higher between one and five years and approximately twice as high in the 5-14 year age group.

There are a handful of other Polish studies which give an indication of variations in health behaviour according to socioeconomic group, though these largely refer to adults. Given what is known of consultation rates in Britain, the results may not be generalisable to children. A national study of a representative sample of 1,710 urban dwellers (this excluding the rural population) concerning the type of primary health care facility typically used was carried out by the Public Opinion Research Centre (OBOP) in 1967. The results of this study are summarised in Table 6.7. Clear groups differences emerged,

TABLE 6.7: Place of Treatment by Level of Education (%) (Poland, 1967).

	Incomplete Primary	Primary	Incomplete Secondary	Basic Vocational	Secondary	Incomplete Higher	Higher
Rejon Polyclinic	64.5	64.1	63.0	45.2	59.3	53.5	37.7
Workplace Polyclinic	12.7	13.1	10.2	37.4	11.4	12.8	17.0
Specialist Outpatient Clinic	2.5	4.2	4.5	3.2	5.2	5.8	7.5
Medical Cooperative	-	1.0	1.6	1.6	2.3	4.7	3.8
Private Physician	6.3	7.1	8.5	1.3	9.9	10.4	15.1
Does not seek treatment	8.3	3.3	4.5	2.9	4.7	4.5	1.9
No data	5.7	6.4	7.7	5.8	9.0	8.1	17.0
Base (=100%)	158	618	246	155	344	86	53

Source: Ostrowska, A. (1975), Table 39, p. 69.

with those with higher education using the rejon polyclinic less often, but using specialist out-patient clinics, medical co-operatives and private physicians more frequently than other groups. Those with least education were also more likely not to consult at all in the case of illness.

More recent findings reported by Titków (1976) make specific reference to children. In a study of 1,165 Warsaw inhabitants, 92 per cent of all respondents made use of state primary health care facilities for their children, although those parents seeking additional private health care mainly comprised persons with higher education. The study also found that individuals with higher education were advantaged in terms of their access to specific drugs (imported drugs being considered superior to Polish drugs).

It is also worth mentioning that clear patterns of hospitalisation emerged in the same study. Of those who had been in hospital, 66 per cent of unskilled manual workers had used the local rejon hospital while only 32 per cent of those with higher education had done the same. Similar findings were reported for maternity cases.

> "According to general opinion, rejon hospitals offer medical services which are of inferior quality to those provided by the Medical Academy teaching hospitals and Research Institute hospitals. General opinion also has it that circumvention of the territorial principle governing inpatient treatment is only possible if a special effort is made, in particular it is possible if one knows how to go about making contact with the right doctor"
>
> (ibid.: 34).

Informal ties are important in this regard; Ejsmond (1969) discovered that a significant proportion of his hospital respondents had an acquaintance with a member of hospital staff, which "allows one to suppose that they were making use of certain informal privileges" (p. 369). Inasmuch as a higher educational level increases the possibility that a person will have within his or her network of friends and family, or just outside it, someone who is a doctor, it will also act to improve access to care.

Social status also acts in more diffuse ways to improve access to primary health care. A separate study conducted in 1975 on a representative national sample of respondents compared those patients who waited the shortest period of time in a rejon polyclinic, i.e. less than 30 minutes, with those with the longest waiting times, about three hours (Ostrowska, 1983). It was found that the former group included a

larger number of white-collar workers and the intelligentsia, while the latter group consisted largely of unskilled workers. Moreover, these were intra- and not inter-polyclinic differences. Ostrowska concludes that in "the very same outpatient clinic it is much easier for the people with a higher social status to overcome all the bureaucratic and administrative barriers before entering the doctor's room; therefore, they are promptly seen to and in a much more satisfying way".

Finally, it should be noted that in Poland, level of income directly mediates access to care, or better care, not only through the ability to pay a fee for private medical services, but also through the ability to subvert bureaucratic channels in the socialised sector by giving a gift, tip or bribe:

> "the wide-spread practice of bribes and tips for doctors, nurses and staff in the sanatoriums and other health establishments produces a significant inequality of treatment and 'fluidity' of waiting lists, which discriminate against the worst off economically and socially"
>
> (Łoś, 1980a: 69).

Psycho-social Aspects of Health Care

One important area of difference to emerge between the two countries under study has been the nature of family-state interaction. We saw in Chapter V the relatively small extent to which the family in Poland is the site of social welfare or social policing. This theme has been echoed in the present chapter, with the historical importance in Britain of health visiting and the "intermediate zone" in which it has taken place, yet its relative unimportance in practice in Poland. In general terms, the fate of the professions of social work and health visiting have been similar there. Both were introduced by administrative fiat in 1966, the employment of both has fallen far short of target and those which do exist have become largely administrative workers. The network of health service social workers was to have been complete by 1980, but in 1979 there was still only one for every 15,947 urban population (i.e. even fewer for the population as a whole) (Praca i Zabezpieczenie Społeczne, 1981). As far as health visitors are concerned, only 25 per cent of the employment target has been reached (ibid.), and it has been estimated that only about three hours of their working day is actually spent on home visits (Loch, 1980). As in Britain, these visits are not confined exclusively to children.

To an extent, the GPs themselves have also identified the family as a whole and the interpersonal relationships within the family, as their proper concern. As has been seen, this idea has been clearly expressed in the recent report Healthier Children - Thinking Prevention (RCGP, 1982), and is an idea which has already been translated

into practice by some GPs. In terms of both ideology and practice, this stands in contrast with Poland where the only avenue of medical intervention in the family as such is in the area of human reproduction.

Taken together, these are indications that "the social" has taken a different form in modern medical care and welfare (such as exists) than has been the case in Britain, for as Armstrong (1983: 14) has noted, the Dispensary in Britain was an attempt "to map and survey the social relationships of the child in the community proper" which recruited social workers, health visitors and school nurses to visit children and their parents at home.

Any account which tries to deal with this area must go beyond normative descriptions of professional work (such as that given by Nocon (1982)). For a normative account is not yet the facts, and facts, as Parkin (1981) has observed, are not yet social meanings. Reference has made in Chapter V to the extent to which the necessary pre-requisites for "social policing", i.e. moral consensus and a degree of identification with the institutions of the state, are lacking in Poland. This was seen to be associated with a split in Polish social consciousness between civil society and the State. It was argued that this consciousness might be expressed in terms of a barrier between public and private domains, but one whose essence, and therefore the nature of public and private domains themselves, is problematic. It was postulated, therefore, that a greater barrier exists in Poland between public and private domains, but only insofar as the

former refers to interactions based on state-bureaucratic principles. For example, on the level of observation, ease of access to the home is less for state representatives but greater for those linked by informal ties, than is the case in Britain. Because the theoretical divisions put forward here refer not only to the objective characteristics of external events, but primarily to divisions within the individual by means of which meaning is attached to these external events, what we are ultimately referring to are differences of social psychology.

There are further dimensions to this question, for the relative absence of "the social" is also in the nature of things, a relative absence of "the psychological". Freudian theories and applied psychology in general have failed to take hold in Polish society. This has been associated with a lack of the proliferation of expert psychological advice on child-rearing which has been a feature of Western society. Again, what is involved is not so much a failure to introduce psychology-based practices but rather a failure of these to take hold and develop as an integral part of social life in a way which would be recognisable in Britain (cf. Frydman, 1983). Spock has been published but is not discussed in any professional writings.

The fact is that the cultural and psychosocial environment does not favour the assimilation of psychological categories as a meaningful way of understanding or dealing with reality. Here it is instructive to contrast Poland's experience since the existence of the old Republic with the account given by Sennett (1977) of the degradation

in American and other Western societies of an inherited culture, the public realm, and the rise of what he calls the "intimate society" which was crucially associated with the rise of secularism and capitalism. This involved a shift from a transcendental to an immanent code of cognition. In the 18th century, "the order of Nature was ... an idea of the secular as the transcendental" (ibid.: 21), but the secularism of the 19th century was

> "based on a code of the immanent rather than the transcendent. Immediate sensation, immediate fact, immediate feeling, were no longer fitted into a pre-existent scheme in order to be understood. The immanent, the instant, the fact, was a reality in and of itself"
>
> (ibid.: 21).

The meaning of human life came to be thought of in terms of a personality which was immanent in appearances.

Sennett's argument, which cannot be dealt with in full here, has plausibility for aspects of Western life. For Poland, however, one might speculate that, given the lack of historically developed capitalist relations, the ancien régime of the partitioning powers, and the failure of the post-war government to legitimise itself, there has been a degree of cultural survival of a transcendent and therefore anti-immanent code of cognition. Davies has argued for the survival of tradition and social structures as follows:

> "(w)hat cannot be questioned, however, is the durability of traditional Polish society. Whereas many characteristic features of the old Republic were destroyed, or were transformed out of all recognition, its social structures and traditions remained essentially intact over several centuries, thereby proving remarkably

> resistant to political and economic change. In this, they often contrived to transcend the Partitions, and provide one of the few strands of relative permanence and continuity in modern Polish history"
>
> (Davies, 1981: 254-5).

What is argued here is that another, no less important element of continuity in Polish history has been a mode of thought, a way of apprehending reality typical of ancien régime society, which Sennett refers to as transcendental. Certainly the Polish historical experience since the end of the 18th century has militated against a belief in unitary and self-obvious reality, and the transcendental idea of the survival of the nation and the moral values associated with it persist to the present day. This experience is not conducive to viewing reality in psychological terms. With the rise of immanent culture and its associated ideology of intimacy, personality appeared in public. This was a sine qua non for those professions whose task it was to cross the boundary between public and private domains. It is plausible that it is the lack of such a culture which accounts at least in part for their absence in Poland.

Notes

1. For more detailed accounts in English of the structure and organisation of the Polish health service, see especially Russell-Hodgson (in preparation), also Roemer and Roemer (1977: Ch. 1).

2. Dz. Urz. Min. Zdr. 1948, Nr. 66, Poz. 434.

3. The Polish word gmina derives from the German Gemein(d)e and refers to a "lower administrative unit".

4. These are the Institutes of Hygiene, Medical Information, Drug Research and Control, Food and Nutrition, Psychiatry and Neurology, Tuberculosis, Mother and Child, Oncology, Industrial Medicine, Medicine of Mining and Heavy Industry, Occupational Medicine and Rural Hygiene, Marine Medicine, Rheumatology, Balneoclimatics.

5. This represents a point of contrast with the Soviet health care system inasmuch as within the latter, hospitals do not typically offer outpatient care.

6. The section which follows is largely based on Indulski et. al. (1978).

7. These are in Białystock, Olsztyn, Gdańsk, Szczecin, Wrocław, Opole, Katowice, Kraków, Kielce, Lublin, Warsaw, Poznań.

8. Internal figures provided by the Department of Educational Medicine, IMiDz, Warsaw.

9. According to the Programme for the Improvement of Health Care for the Developmental Age Population 1975-1990.

10. As a matter of interest it is worth noting that while public health remained undeveloped within Poland during the inter-war years (although Marcin Kacprzak was a well-known proponent of public health ideas at

this time), the major force on the international public health scene then was a Polish Jew named Ludwik Rajchman who has been described as "the man who was the real author of the broader conceptions of international health work that developed between the two World Wars" (Howard-Jones, 1978: 83). As medical director of the Health Organisation of the League of Nations, he was responsible for the League's move into areas far removed from the purely quarantine measures with which international public health had previously been concerned. He encouraged work in such fields as nutrition, housing and rural hygiene which would be widely applicable in establishing the minimum standards towards which all countries could strive.

11. In 1962, a public opinion survey conducted by the Public Opinion Research Centre (OBOP) revealed that male doctors were significantly more frequently preferred to female doctors. A questionnaire study conducted 15 years later by the Institute of Social Medicine at the Łódź Medical Academy, showed that this state of affairs had been reversed. Twice as many respondents preferred women doctors, while, significantly, only men over 40 preferred men doctors (Instytut Medycyny Społecznej A.M. w Lodzi, 1979).

12. Personal communication, Dr. W. Czekalska, Department for the Organisation of Child Health Care, IMiDZ, Warsaw, October 1982.

13. Dz. Urz. Min. Zdr. 1950, Nr. 14, Poz. 122, Okólnik 57/50 concerning temporary guidelines for the organisation and conditions of use of socialised health service institutions in the field of maternal and child health; Dz. Urz. Min. Zdr. 1954, Nr. 20, Poz. 115, Instr. 52/54 concerning a change to the instruction concerning milk kitchens and feed distribution centres.

14. Dz. Urz. Min. Zdr. 1950, Nr. 14, Poz. 122 op. cit.

15. But Blaxter and Davidson (1982) have noted with surprise the extent to which the members of the families in their study were in fact treated

by different GPs.

16. With the exception of the proposal concerning the District Handicap Team.

17. For a detailed analysis of this report, see Davies (1983b).

18. See Chapter I, note 1.

19. Cf. Morris (1980).

20. The following section is based on extensive interviews with Sławomir Izak at TPD headquarters in Warsaw during November 1982.

21. Another self-help group (for children with coeliac disease) was formed under the auspices of the TPD in 1982 on the initiative of the father of a child suffering from the disease.

22. Marcin Kacprzak speaking at the 1957 Polish Congress of Education.

23. Surveys carried out in the Warsaw voivodeship have shown, for example, that on orthoptic holidays an outstanding improvement was obtained in 60 per cent of cases and no improvement in 7 per cent of cases; on speech therapy holidays, outstanding improvement was achieved in 65 per cent of cases and no improvement in 5 per cent of cases, while holidays for diabetic children resulted in a weight gain for 70-90 per cent of children, with an overall reduced need for insulin (Cerańska-Goszczyńska and Serejski, 1970).

24. Although health colony holidays form a part of the system of health care for children, they are not organised under the auspices of the MZiOS. The organisers are the same as in the case of ordinary colony holidays and include local state administration departments, including the voivodeship education department, schools and other educational establishments, workplaces in the socialised sector as part of their social welfare activities and youth and voluntary organisations.

Local government and workplaces often delegate organisation of the holidays to the voluntary organisations, and in fact in 1979 the Society of Children's Friends (TDP) organised 40 per cent of all health colony holidays (Radiukiewicz and Chojnacka, 1980).

25. Solidarity demanded that this should be raised to 6 per cent of the GNP.

26. As in Britain, separate health services are provided for the military in Poland. Separate services are also operated by the Ministry of the Interior and Ministry of Transport for their respective employees and their families.

CHAPTER VII

CONCLUSIONS

Ultimately, there are no limits to what might be considered in an analysis of the division of labour in child health care, for we are unable to circumscribe all the factors which directly or indirectly impinge on our health. The approach adopted here recognises the super-ordinate importance of both class and gender divisions in determining the nature of child health care. This at once broadens the conventional concept of what health care is and establishes certain limits to the scope of the study. Traditionally, health care has been viewed as the domain of trained medical and para-medical professionals. Recently, however, calls have been made to recognise the primacy of the health care work done by women within the family (Stacey, 1984; Graham, 1979; 1984). This study therefore incorporates an analysis of the organisation of parental responsibilities for health within the family, and the influence of these gender divisions on income from paid work in the public domain. Similarly, the state is conceived here as having an augmented role in health care. For in addition to centrally directing and funding a health service, the state formulates social and employment/unemployment policies which are relevant to the sexual division of labour both within the family and in the labour market, and which also are important in determining what resources are available to families for the health care of their children. The concern for the distribution of what Graham (ibid.) calls health resources which runs through this study reflects an espousal of the view that variations in health are primarily, but not solely, to be explained in material and structural terms. It should

be clear that thus defined, the study excludes from its ambit vast areas of public activity which might reasonably be held to influence health, e.g. food production, industrial pollution, military activity and so on.

The central concern for the influence of role allocation on the basis of sex, and of class divisions on health and health care brings us face-to-face with the main legitimating claim of Poland's state socialist government. This legitimating ideology is important for two reasons; in the first place as Miliband (1979) has pointed out, capitalism as an economic and social system tends by virtue of its very existence to produce the conditions of its own legitimation. Under capitalism, subordination status tends to breed "its qualified acceptance rather than its total rejection" (ibid.: 235). But where capitalism has been superseded by another form of social organisation, this belief is suspended. State socialist systems, in radically transforming social, economic and political structures, have had to generate and maintain specific legitimating arguments; these present an idea of social justice based on social equality in general and sexual equality in particular, with the abolition of private economic power and the right of everyone to participate in the process of socialised production as a means to this end. Secondly, the ideology of equality, particularly of sexual equality, was important in a mobilisation programme which saw in women a valuable economic resource. However, to the extent that expanded female employment and educational opportunities were unaccompanied by an equal commitment to sexual equality within the home, or to radical changes in the status and authority of women

outside the family, these innovations may be seen as a reflection of the necessity of introducing certain dimensions of sexual equality to serve the purposes of a planned economy, just as Marshall (1963) has seen civil citizenship as a necessary prerequisite of the development of a competitive market economy.

It would be generally agreed now that socialisation of the means of production, though important in itself, has not been sufficient to bring social equality to state-socialist countries, nor has mass economic participation been sufficient for sexual equality (Heitlinger 1979; Scott, 1978; Lapidus, 1978). What these things have done rather, and this emerges clearly from the present study, is to have altered the meaning of both social and sexual equality. Firstly, poverty in Britain has to be seen in terms of the ownership and control of private property, whereas in Poland as in other state-socialist countries where "the major inequalities are created by administrative allocation" (Szelenyi, 1983), poverty is properly defined in terms of political power, privilege and favour, and the facility for subverting established bureaucratic channels. Secondly, whereas the enormous "wealth gap" which persists in Britain has no Polish counterpart, there is a greater degree of variation in Poland in the distribution of such vital health resources as food, housing and sanitation. These differences are to some extent the result of differences in national wealth. But the highly structured nature of the Polish data indicates the persistence of economic and political factors which impose limits to social equality.

The consequences of poverty are therefore particularly severe

in Poland in terms of physical survival. In global terms, the infant mortality rate is roughly twice that of England and Wales. But being poor in Poland increases by a factor of seven the chances that a child will die between the first and twelfth month of life, deaths during this post-neonatal period being the most sensitive index available of the effect of socio-economic factors on health. Although direct comparison with England and Wales is impossible here, the social categories being based on education in Poland and occupation in England and Wales, nevertheless this 7:1 ratio is significantly greater than the 3:1 ratio which has persisted in England and Wales between the post-neonatal mortality rates in occupational classes I and V. From the data available it is impossible to say whether these mortality differentials are steady in Poland as they have been in Britain, or whether they have been decreasing over time. What is known is that the gap between urban and rural infant mortality rates has been steadily narrowing, to the point where in some voivodeships rural rates are now lower than urban rates.

Quite clearly, long-standing sexual equality under the law in Poland and the more recent increases in the female labour force have had little impact on the domestic division of labour - or to the acceptability of women in authority outside the home. The utilisation of women as an economic resource under these terms has given, as Lapidus (1978) has pointed out, a transformed meaning to sexual equality, where utilitarian replaced libertarian and humanitarian concerns. In both Poland and Britain, women remain the primary domestic workers and health carers. Public policy may have transformed women's economic

role in Poland, but public policy has also, no less than in Britain, reinforced the traditional allocation of roles within the family. The woman's place is not the home but she does have major responsibilities to both home and workplace, while the man does not. This "dual role" has become equated in Polish social consciousness with sexual equality, and it is the value of sexual equality itself which has become debased as a result.

What fundamentally distinguishes Polish from British social policy is in the first place, its explicit recognition of the balance female workers have to maintain between production and reproduction. It does not seek to shift this balance, but does introduce some flexibility so that women's "two roles" may be articulated. This is evidenced, for example, in generous maternity provisions, in the special child care leave, and paid child care leave available to employed women with young children under four years of age. In a sense, these policies may be seen as involving a transferral of paid time from the place of employment to the domestic domain. To some extent this flexibility is created in Britain by women leaving and then re-entering the labour force, often in a part-time capacity - a solution which operates at substantial short-term and long-term cost to themselves.

The second crucial distinction between Polish and British social policy to concern us here is the absence of a comprehensive scheme of social assistance in Poland. British social policy has historically been concerned with the provision in a class-divided society of an assured level of subsistence to protect the poorest against destitution.

In 1984, supplementary benefit maintains a greater section of the population than anyone ever imagined it would. Unemployment in Britain is a major and rapidly growing cause of poverty among families with children. Between the end of 1980 and the end of 1981, the number of children on supplementary benefit because their parents were unemployed rose from just under 500,000 to 821,000, while the DHSS estimate for 1983/4 puts the number at nearly two million (Graham, 1984). Unemployment cannot be said to be a direct and major source of poverty in Poland - nevertheless, the question of low wages remains as does the absence of guaranteed subsistence for those who fall out of the labour market for one reason or another. One-parent families suffer particularly badly from this combination of circumstances. These families are characteristically among the poorest in both countries. In Britain, this poverty has been specifically linked to the low earnings of women (ibid.); this is true of Poland also, but the situation there is aggravated by the fact that almost all families need the wages of two earners to survive. The unfavourable position of British women in the labour market leads many mothers to claim state benefits which provide a regular source of income, although the value of this income has been declining in recent years. Thus while for 70 per cent of male-headed one parent families the main source of income is earnings, this is true for only 45 per cent of female-headed one parent families (ibid.: 95).

Earnings represent the only source of regular income for lone mothers in Poland, though these may be enhanced by a variety of benefits designed to "equalise" the standard of living between families

with children. It is an arrangement which leaves all lone mothers economically vulnerable, especially those who are unskilled workers - female unskilled labour being "out on its own" as far as low pay is concerned. This is reflected in a dramatic fall in the divorce rate among families with more than one child. Moreover, the "equalising policies" which have been reviewed here are simply not up to the task of dealing with poverty as it exists in either one or two parent families in Poland. Indeed, on the evidence which has been marshalled in this study, it is open to question whether they "equalise" at all. Within the range of benefits considered, there would appear to be three mutually contradictory principles underlying their distribution.

(1) They may be distributed according to the ideological "equalising" principle of "to each according to his need".

(2) They may be distributed according to covert or explicit political criteria.

(3) They may be distributed along informal channels which subvert bureaucratic priorities.

These three principles can, and often do, overlay each other. However, although they have very different consequences in terms of equality, their co-existence need not undermine the system. For to the extent that bureaucratic structures allow the realisation of particular goals, they also gain a kind of legitimacy, as Podgórecki (1981) has pointed out.

On one level, all the benefits which have been reviewed here have been distributed, more or less imperfectly, according to an

equalising principle. Yet the distribution of child allowances is governed by an additional political principle in that separate more advantageous rates apply for the militia and the military. Day care formally accords priority to lone mothers and the less well-off, yet access is often gained through non-bureaucratic channels. The range of benefits in kind which are available through the occupational welfare system perhaps exhibits the greatest degree of antagonism between the three principles of distribution enumerated above. Some benefits do go to families most in need, but there is no systematic relation between needs and benefits. On the other hand, occupational welfare is a major if unquantifiable form of political reward, while informal contacts and channels of information are also significant in determining the distribution of available benefits. The data which have been assembled concerning access to professional health care confirms this pattern. From one point of view there is near-universal access to free care. But there is also political access to privileged care - the so-called "fourth directorate", and informal access which operates through the giving of bribes, the payment of private practitioners or the mobilisation of personal contacts.

How the distribution of earnings, benefits and access to goods and services has varied over time in Poland has not been a matter of central concern to this study. However, the evidence would seem to suggest that, as with sexual equality, we are dealing with complex social dynamics which by no means guarantee progress towards these specific social goals. In this, the evidence contradicts conclusions drawn, for example, by Ferge (1979) in the case of Hungary, but is

supported on the other hand by the writings of Polish sociologists such as Malanowski (1981) and Staniszkis (1981), both of whom note a marked increase in social inequalities in Poland during the seventies. Secondly, although the development of a more rigorous class analysis is not encompassed within the present study, the empirical data which it presents do lend themselves to a more synthesized theoretical contribution to the study of class in state-socialist societies. For example, although Hirszowicz (1980) and more recently Littlejohn (1984) argue that the intelligentsia do not constitute a separate social class, the evidence here indicates that families where at least one parent has higher education systematically occupy a favoured position within the distribution of health resources, and within the distribution of health itself.

In both countries, professional health care for children is provided free-of-charge at point of contact through a universally available socialised health care system. Poland, however, is distinct in operating an organisationally discrete integrated paediatric service - a reflection of the sectoral priority accorded to mothers and children as a demographic subgroup, and of the degree to which the health care system is hospital-dominated. In Britain, the child health clinics which are so prominent in prevention derive from a class orientation in health care and still embody the remnants of a welfare model in the work they do. In both countries today, clinical surveillance forms the backbone of prevention in child health care, and it is probably true that few children in either country fall through this surveillance net. Nevertheless, it is tenuous to argue in the case of Poland,

as Littlejohn (ibid.) has argued in the case of the Soviet Union, that the use of mass surveillance procedures means that the provision of health care is related to need - even if this is restricted to medically defined need. In the first place, it has been shown that there is no inevitable link between knowledge of an abnormal or pathological state and its treatment. Secondly, the surveillance programme is not in practice as comprehensive as in claimed, as has been evidenced in the case of children with diabetes. Neither state nor medical authorities are able to give a reliable estimate of the numbers of such children in Poland today. Thirdly, underfinancing of the health service has been shown to have a clear pathogenic role. Fourthly, although the present study has shown that in Poland no less than in Britain, there is a strong and consistent relationship between health, as measured by the infant mortality rate, and a range of socio-economic variables, nevertheless no systematic knowledge base is being generated which would indicate the structural distribution of health needs. The analysis of Polish infant mortality rates presented in this study, for example, is based on a large scale one-off research project conducted by GUS, the full results of which were in any case subjected to restricted circulation. Little is known either, about utilisation of services. To the knowledge of this author, there has been only one large scale post-war study of consultation rates among Polish children. This was carried out in the late sixties and compares rates according to age, sex and urban/rural place of residence.

A major dimension of child health work in post-war Britain has been the way in which it has encompassed the social by looking to the

nature of interpersonal relations within the private domain - a phenomenon which has recently been highlighted by Armstrong (1983). The corollary of this is the fact that a major part of child health work in Britain, that done by health visitors and clinical medical officers, has been ascertained to take place in an "intermediate zone" (Stacey and Davies, 1983), that is to say, within the public domain but drawing on a mode of action belonging to the private domain. There is a significant point of contrast to be made here with child health care in Poland. Despite the fact that both professional social work and health visiting were centrally in Poland introduced in the mid-sixties and a subsequent push to increase training programmes made in the mid-seventies, these professions have failed to take on the role which was planned for them. The clinic, not the home is the locus of professional health care (1), and the mode of interaction in such care, given the participlants are linked by purely bureaucratic criteria, is one which is appropriate to the public domain. The argument put forward here is that this pattern of health care delivery is not simply the result of historical accident, organisational factors or even of lack of funding. It is closely linked with specific psycho-social factors, and this in turn generates certain hypotheses concerning the mode of functioning of the caring professions in general. For example, it leads us to expect that there will be less carry-over of the caring and affective components of nursing when it is performed as paid work in the public domain, rather than in the private domain. It suggests that the political setting does influence the tone and emotional content of the interactions of professionals and their clients. To date no such comparative studies have been carried out. We do know, however,

that while a caring and expressive role are among the Polish nurse's statutory duties, there has also been widespread criticism of what is described as the formalistic approach and lack of expressive content in the work of both doctors and nurses in that country (Tymowska and Włodarczyk, 1984).

If it had not been for the use of a conceptual framework which distinguishes public and private domains and insists on viewing each in terms of the other, this last important point of contrast might have been missed. However, it is this very finding which leads the analysis into a more theoretical consideration of the nature of the public and private domains and the way in which they interact in the two countries; it is at this point that our conceptual tools press for treatment as objects of analysis (cf. Barrett and McIntosh, 1982). The fundamental factor to be taken into account is the fact that the Polish government came to be rejected in the very terms which it had used to legitimise itself. This is why Staniszkis (1981) has written of an "ideological trap" which the Polish government had created for itself. It is important to note, however, that while the social perception of social inequalities systematically rose during the seventies (Koralewicz-Zębik, 1984), this was unaccompanied by any social consciousness of inequality based on sex (ibid.). Ideological claims for sexual equality in Poland have been successful, despite the social facts, and the authorities certainly did not lose legitimacy on this count. The lack of political legitimacy acted in two ways; on the one hand it fostered a social consciousness where state is wholly distinct from society - it creates a " counter-community" (Staniszkis,

ibid.), and on the other it dramatised history and highlights the need for a historical frame of reference.

The public domain in Poland contrasts with that in Britain in being divided into two distinct parts: that associated with the state and based on bureaucratic principles of interaction, and that based on informal ties. On the one hand, evidence shows that there is a clearer delineation of the private domain from the state (but not the non-state) sector of the public domain than is the case in Britain. At the same time, the functioning of the public domain is crucially determined by the subversion of bureaucratic by informal mechanisms. This, of course, is true at a certain level for Britain also, as Miliband (1973) has amply illustrated; what I am suggesting here is that the phenomenon is a more widespread one in Poland, one which permeates every level of transaction.

The corollary of less welfare has been in Poland a smaller degree of administrative invasion of the family. The failure of the representatives of psychology-based professions and representatives of state administration to cross the line between public and private domains has had diverse implications. There is the central paradox, when viewed from the British perspective, of the mass employment of women and the lack of "women's place" ideology on the one hand, and the survival of a relatively intact private domain as women's domain on the other. Women in Poland are therefore first and foremost controlled as workers in a devalued public arena, yet it is primarily from their position and role within the family that they continue to

derive status and respect. Furthermore, it is here in the private domain, rather than in the occupational sphere that paid work for women has had its main impact in terms of raising and bolstering women's status. This is a combination of circumstances which has created an area of subjective advantage for Polish women with respect to women in Britain, and one which is to be set against a higher overall work burden (2). It also represents an area of subjective advantage over Polish men, one to be set against the fact of "dual exploitation", insofar as Polish men are both controlled in, and derived their status from, a devalued public domain. However, this is a confining if comforting advantage, for the primacy of an unpermeable family and the debasement of public institutions under a government which suffers from a crisis of legitimacy act a strong structural reinforcements of existing gender divisions. This has implications for theoretical and practical feminism, for it indicates that there are important political in addition to material enabling factors for female emancipation.

Notes

1. Home visits by doctors are, however, made relatively frequently, particularly in cases of suspected infectious illness.

2. This may partly explain the low suicide rate among Polish women. In 1979, there were 0.5 suicides per 10,000 female urban population and 0.3 per 20,000 rural population, as compared with male rates of 2.1 and 2.4, respectively (RSOZ 1981: 56,57). In Eng/Wales, the corresponding rates for 1980 were 0.67 for women and 1.09 for men (WHO, 1982).

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